

# Reflecting on culture in medicine

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## Second-year medical students' online discussions

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# ABSTRACT

This thesis reports on a qualitative study of the role of reflection in the development of second year medical students' intercultural competence. Reflective capacity is an important professional competency and is crucial for the development of intercultural competence in medicine. Few studies have examined students' reflective thinking in relation to intercultural competence and no studies have done so in a medical context. This study aimed to evaluate students' levels of reflection in online discussions and to explore the connection between students' reflections and intercultural sensitivity—a component of intercultural competence.

The context of the study was two online discussions with 123 students and 12 tutors in a Culture and Health unit in second-year medicine at a New Zealand university. In the first online discussion, students were asked to apply Hofstede's dimensions of culture to the actions of the doctor, patient, or family depicted in an intercultural clinical case reading and analyse how cultural differences impacted patient outcomes. In the second, students considered a documentary film and discussed how a doctor's culture and perceptions may impact his or her ability to provide culturally competent care. Each online assignment required students to make at least one post and to reply to a classmate's post.

In this thesis, I explore 1) students' levels of reflection in the two online discussions, 2) the quality of intercultural sensitivity observed at each level of reflection, and 3) the factors that fostered or hindered students' reflection and intercultural learning online. Data included students' posts in two online discussions and written feedback from students and tutors. In order to assess students' levels of reflection, I adapted a framework from the literature that identified three levels of reflection: 'understanding' (L1), 'practical reflection' (L2), and 'critical reflection' (L3). At 'understanding' (L1), students described cultural concepts but

did not relate them to personal experience or practice situations. At ‘practical reflection’ (L2), students applied course content to intercultural clinical cases and related new knowledge to prior experience or practice situations. At ‘critical reflection’ (L3), the student reviewed their assumptions, and showed evidence of the development of a new conceptual framework. The majority of posts were at ‘understanding’ (L1). Only one student demonstrated ‘critical reflection’ (L3).

To evaluate students’ intercultural sensitivity, I used the Intercultural Development Continuum, which indicates their ability to notice cultural differences, analyse their impact, and identify strategies for effective intercultural interaction. The continuum is based on the notion that as a person’s intercultural sensitivity increases they move from an ethnocentric to an ethnorelative mindset. The stages of the continuum range through denial, polarisation (i.e., defence or reversal), minimisation, and acceptance, to adaptation. Only a few students at ‘understanding’ level exhibited ‘defense’, an ethnocentric perspective. These students made simplistic comparisons that portrayed unfamiliar cultural characteristics as ‘wrong’ while representing familiar cultural characteristics as ‘correct’. Most students at all levels of reflection viewed culture from a position of ‘acceptance’, an ethnorelative perspective, in that they recognised how individuals’ behaviour made sense from a particular cultural worldview. What distinguished students at ‘practical reflection’ level was the ability to relate concepts of culture to themselves, their prior experience or their future practice. Two students at ‘practical reflection’ level demonstrated ‘adaptation’ or the ability to shift frames of reference and engage in cultural empathy.

The online discussions successfully encouraged reflective discussion and recognition of multiple perspectives. However, the design of the online assignment, students’ surface approaches to the online task, and the public and obligatory nature of online reflection

hindered some students' reflection and participation. The study revealed how complex it was to evaluate reflection; other limitations of the study were noted.

The study findings add three important insights to existing literature on reflection and intercultural competence in medical education. First, it revealed that even at 'understanding' level students recognised multiple perspectives and demonstrated valuable insights into the impact of culture in a medical context. This finding differs from prior research that found that non-reflective students struggled to recognise multiple perspectives. Second, the study confirmed and extended prior research indicating that reflection plays a key role in students recognising their own worldview, and its impact on their beliefs, which may differ from others'. Third, the study findings suggest that online discussion is a useful tool for encouraging students to think more reflectively about the implications of culture in medicine.

Study findings highlighted several implications for those wishing to introduce blended learning approaches in medical education, especially those involving reflection. A key implication is that programme coordinators must ensure the 'buy in' of teaching staff, and recognise the time required to monitor and facilitate online reflection. Furthermore, where the learning activity involves reflective tasks, staff and students need to have a shared understanding of what constitutes reflection and be clear about the purpose of any online discussion. Future studies are needed that explore how formative feedback on students' online reflection can encourage deeper reflection over a longer timeframe. Further research is also needed that explores the impact of staff attitudes on students' intercultural learning.

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# Chapter One

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## Introduction



In this thesis I explore the role of online reflection in the development of intercultural competence in second-year medical students. This chapter sets the scene for this thesis by first explaining the background to the study. I then introduce the study, including my research questions and rationale for using an interpretive qualitative research approach. Following this, I explain some of the key concepts I draw on in this thesis and discuss the relevance of cultural competence to the practice of medicine in New Zealand. I conclude the chapter with an outline of the overall thesis structure.

## Origins of the study

Recognising other cultures or worldviews begins with being aware of one's own worldview (Bennett, 2009). The seeds of my own interest in culture, and awareness of my own worldview, originated growing up in a bicultural Italian-American family in the United States. As a child I spoke both English and Italian; my grandmother, who was an immigrant to the United States, spoke only Italian, and cared for me during my early life while my mother was working. As a result, I encountered two very different, sometimes contradictory, worldviews—that of my mother who was a second-generation, college-educated nurse, and that of my grandmother, who was a first-generation immigrant from the 'old world' with no formal schooling. Perhaps as a consequence of my experiences growing up in a bicultural family, as an adult I chose to study Mandarin, travel to many parts of the world, and pursue a career in international education.

My experiences living and working in China, and my career in international education have contributed to my interest in learning about culture and the challenges of effectively communicating across cultures. In my professional role, I witnessed the struggles that international students face adapting to a new environment. I also became aware of the challenges that higher education teachers face trying to integrate international students into

new learning environments. It seemed to me that the different life experiences that students brought to the classroom went largely untapped as a resource for learning. Thus, the opportunity for all students to benefit from sharing their perspectives, based on their different life experiences, remained largely unrealised.

After working in international education for over 20 years, I had the opportunity to pursue postgraduate course work. Much of my course work was online and I began to appreciate the dynamic learning that could occur through online discussion with peers. As a result, I chose to explore the literature on the impact of culture in an online learning environment for my early postgraduate research. Two findings from this literature review stood out. Firstly, for students who were shy or embarrassed to speak up in class, the asynchronous online environment provided a space where the reactions of peers were less of a concern (Gerbic, 2006; Moore, Shattuck, & Al-Harthi, 2005). Secondly, the online environment provided a space where students were less worried about misunderstandings that occurred because of accents (Moore et al., 2005). These findings spurred my interest in the potential of the online environment to provide both a space in which the barriers associated with the face-to-face classroom could be overcome, and an opportunity for students from different backgrounds to learn about culture from one another online.

While studying, I collaborated with the Course Coordinator for the 'Culture and Health' unit in second-year medicine at the University of Otago. My knowledge of intercultural communication, developed over many years as an international student adviser, and my language study and work in China, provided a platform for providing advice and suggestions for the 'Culture and Health' unit. The unit was an early introduction to the impact of culture in medicine for second-year medical students (see Chapter Four for details). As I surveyed the literature that informed the unit and worked with the Course Coordinator in a volunteer consulting role, I became increasingly interested in the role of

reflection in the development of students' professional practice and intercultural competence. Consequently, I decided to focus my research on the intersection between medical students' reflective ability online and the development of intercultural competence.

## The importance of reflection

I view reflection for learning as a thinking process that involves the use of both thoughts and emotions to explore a relatively complex idea, experience, or problem; this process can lead to new understandings (Boud, Keogh, & Walker, 1985; Moon, 1999). Reflection is widely thought to improve learning and professional practice in higher education (Kember, 2008; Rogers, 2001; Ryan & Ryan, 2013; Wear, Zarconi, Garden, & Jones, 2012). Medical students can use reflection to understand themselves, and appreciate clinical situations in terms of their future practice (Sandars, 2009). Navigating the complexities of medical practice, particularly with respect to decision making in ethically complex and morally ambiguous clinical situations, requires reflective capacity (Reitmanova, 2011; Roberts, Sanders, Mann, & Wass, 2010). To be transformative, reflection should involve students critically questioning an idea or an experience with a purpose—that is, to come to a broader understanding of an idea or experience that is linked to change in actions or future practice (Wear, Kumagai, Varley, & Zarconi, 2012). For these reasons, reflection is considered to be a core competency to develop in medical students (Wear, Zarconi, et al., 2012).

Learning to reflect in complex and rigorous ways is difficult and requires time and practice to do well (Rogers, 2001). Students' capacity to engage in reflection depends on their skills and experience and their view of knowledge (Kember, 2008; Ryan, 2013). For example, a first year student may lack life experience, and view knowledge as black and white, and right or wrong, which could hinder their ability to recognise ambiguity in practice

situations and engage in reflection (Kember et al., 2000). In the early stages, students need clarity about what reflection entails and an authentic context for reflection to occur, otherwise they may view reflection as a ‘recipe following’ exercise (Boud & Walker, 1998). Students need guidance to reach deeper levels of reflection (Ryan, 2013). Group discussion can help students develop their reflective capacity by exposing them to alternative perspectives (Lie, Shapiro, Cohn, & Najm, 2010), and challenging students within a supportive environment can help them consider a situation or idea more carefully (Platzer, et al., 2000).

Reflection is also crucial to the development of intercultural competence in medical students (Lie, Shapiro, Cohn, & Najm, 2010; Tervalon & Murray-García, 1998; Wald & Reis, 2010; Wear, Kumagai, et al., 2012). Reflection can help students identify their own values, beliefs, biases and assumptions (Kumagai & Lyson, 2009) and recognise that they have a particular cultural perspective or worldview (Wear, Kumagai, et al., 2012).

Reflection can also assist students to notice that they may bring unconscious assumptions and biases to their interactions with patients (Wear, Kumagai, et al., 2012). Engaging in reflection with peers and sharing different viewpoints can help students develop a broader understanding of an idea by exposing them to multiple perspectives (Wear, Kumagai, et al., 2012). Exposure to multiple perspectives can help students recognise that their viewpoint may differ significantly from those of their patients, and that these differences can contribute to misunderstandings and miscommunications.

Critical reflection involves “the questioning of taken-for-granted assumptions about oneself, one’s group, or the conditions in which one operates” (Boud & Walker, 1998, p. 15) and/or noticing the broader societal or organizational context of people’s actions (Thompson & Pascal, 2012). When students critically reflect on power and privilege within

society they can recognise how societal factors can impact on the health and well-being of their patients (Wald, Davis, Reis, Monroe, & Borkan, 2009).

Reflection can deepen students' learning (Moon, 1999; Ryan & Ryan, 2013) and encourage 'habits of mind' that assist medical students as they approach the ethical and values-related dilemmas that often characterize clinical encounters across cultures (Wald et al., 2012). The process of becoming culturally competent and appreciating that others may hold different worldviews than oneself typically begins with students coming to an appreciation of their own culture or worldview (Bennett, 2004; Whiteford, 1998). Written reflection is an effective tool to facilitate students' appreciation of their own worldview and help students to recognise the potential for making judgements about people with whom they are not familiar (McAllister et al., 2006). Written reflection combined with facilitated peer-discussion can be especially effective in helping students to recognise the alternative perspectives of patients and learn about the impact of people's different worldviews on medicine (Lie et al., 2010; Roberts, Sanders, Mann, & Wass, 2010).

Online discussions, which combine individual written reflection with virtual online interactions, provide a unique milieu to encourage more divergent thinking and exploration of multiple perspectives (Parker & Gemino, 2001; Picciano, 2002). Where asynchronous online discussions allow time for students to think and reflect, students have time to organize their ideas before writing a post; this in turn creates the potential for more thoughtful discussions than what might occur face-to-face (Curtis, 2006; Harasim, 1993). When students are questioned by their peers, the time lapse allows time to rethink, re-examine, and reframe an issue before responding (Curtis, 2006). Online discussions encourage reflection as students summarise and build upon what others have said, or revise statements that have been misunderstood (Curtis, 2006). There is a written record, in the online discussion, of students' intellectual and emotional reactions as they consider

new ideas (Ziegahn, 2001). Students are able to reflect on what others have said, and their own reactions, and make connections with past experiences in order to formulate new perspectives and learn about culture with peers (Ziegahn, 2001).

## The research objectives

In this thesis I explore how participation in online discussion influenced second-year medical students' reflections about the impact of culture in medicine. The aim of the study was to contribute to our understanding of the intersection between medical students' reflective capacity and the development of intercultural competence. I aimed to examine what medical students' reflections in online discussions could tell us about students' intercultural sensitivity. Specifically, I sought to answer the following questions:

1. What levels of reflection do students exhibit in their online posts about intercultural interactions in a medical context?
2. What is the relationship between students' levels of reflection and their intercultural sensitivity—that is, noticing and analysing cultural differences and identifying appropriate responses?
3. What are the factors that contribute to or hinder online reflection and intercultural learning?

The study is important for several reasons. Firstly, developing medical students' reflective capacity is crucial, as doctors must evaluate best evidence while also recognising their own values and assumptions in relation to the goals, values and beliefs of their patients (Plack & Greenberg, 2005). Reflection is especially relevant to learning about culture in medicine because it involves students reframing problems, questioning their own assumptions and



examining situations from multiple perspectives (David Boud et al., 1985; Dewey, 1933; Kolb, 1984; Schön, 1995).

Secondly, understanding the relationship between reflective thinking and intercultural sensitivity—that is, the ability to notice and analyse cultural differences and identify appropriate responses, can assist educators to recognise ‘where students are’ in their thinking about culture and facilitate students’ capacity to reflect more critically on how their subjective perspective may impact their interactions with patients from backgrounds different than their own. I embarked on this study, hoping to provide valuable insights into the advantages and disadvantages of online discussions as a curricular strategy for supporting medical students’ reflection and learning about culture in medicine.

## **Rationale for a qualitative approach**

There are several reasons why I took a qualitative interpretive approach to this research.

Firstly, an interpretive approach holds that social reality is created through interaction with others, as the individual subjectively interprets their experience in order to make meaning from the interaction (Flick, von Kardoff, & Steinke, 2004). My experiences growing up in a bicultural Italian-American family, my involvement with students from around the world as an international educator, as well as my research in higher education, have confirmed my view that any issue or event will likely be viewed or interpreted differently by people. The lens that we use to interpret our experience is filtered by many factors, such as culture, gender, age, education, socio-economic background—our lived experience. Therefore, there can be multiple interpretations of an experience of an event or reality and different meanings made from it.

Secondly, an interpretive approach is congruent with the aims of this study. An interpretive qualitative approach focuses on understanding reality through analysis of

communication and interaction between individuals (Flick et al., 2004). In the current study, I analysed students' communication and interactions online, and examined what their communication revealed regarding students' ability to be reflective and interculturally sensitive.

Thirdly, an interpretive qualitative approach assumes that an individual's 'objective' life experiences (e.g., income, age, education, etc.) are expressed through their subjective and collective meaning-making—that is, how they make sense of their experience (Flick et al., 2004). An interpretive, qualitative approach is congruent with my constructivist perspective or view of intercultural interactions as the product of how a person construes an experience, rather than what happens to a person (Bennett, 2009). This study explored medical students' ability to notice their own and others' subjective worldview as they discussed the intercultural clinical cases.

Finally, an interpretive qualitative approach is in line with my view of learning as a social process in which students construct meaning (knowledge) through communication with one another (Vygotsky, 1978). Social constructivists view language as the tool that individuals use to construct meaning (Swan, 2005). These ideas influenced my choice of online discussion as a vehicle to examine students' reflective thinking and intercultural learning. The purpose of the online discussions was to situate theories of culture in the real-world context of the clinic and thereby engage students in meaningful discussion (Jonassen, Davidson, Collins, Campbell, & Haag, 1995). I also aimed to expose students to the diverse perspectives of their peers. This approach reflected my belief that students learn best when they are actively engaged with one another in a meaning making process.

In this thesis I use a social constructivist approach to explore the meanings that students articulated about the interactions depicted in the intercultural clinical cases, as well as the meanings that they constructed through interactions with their peers online (Miles &

Huberman, 1994). My aim was to investigate the role of reflection as students learnt about themselves as cultural beings and explored the impact of culture in a medical context and examine the implications for their future medical practice. Data were collected through document analysis of online written posts, collecting students' and tutors' written feedback, and a group interview with the tutors (Grant & Giddings, 2002). I explain more about my methodological approach in Chapter Four, The Research Process.

## **Clarification of terms**

Many of the terms I use in this thesis are highly contested. Therefore, in order to avoid misinterpretation or ambiguity, I clarify my use of key terms below.

### **Reflection**

I understand reflection as involving both thoughts and emotions to investigate an experience or concept in order to learn from it. In this study, reflection is defined as a careful examination and analysis of thoughts, actions and feelings related to the doctor and patient/family interactions depicted in course readings and documentary film that result in new understandings that are interpreted in terms of self or personal experience or applied to practice situations (adapted from (Kember, McKay, Sinclair, & Wong, 2008; Nguyen, Fernandez, Karsenti, & Charlin, 2014; Reitmanova, 2011). This definition informs that analysis of students' online reflection in Chapter Five.

### **Culture and subjective worldview**

Culture is defined as a dynamic set of implicit and explicit rules of behaviour, developed and learned by groups of people (Matsumoto, 1996). These behaviours are influenced by values, norms and beliefs that are shared by a group but experienced differently by each

individual within the group and communicated across generations. In this way, they are relatively stable but have the potential to change with time (Matsumoto, 1996).

In this study, I focus on ‘subjective culture’ (Berger & Luckmann, 1967; Triandis, 1994), which represents an individual’s subjective perspective or ‘worldview’, and includes such things as what one notices or how one differentiates objects or actions in an environment, how one organises and manages communication, and what one values or considers to be ‘good’ or ‘bad’, and so on (Bennett, 2009). For example, New Zealanders in general value humility and modesty, and as a result, they tend to communicate in indirect ways. In making a request, a New Zealander might ‘soften’ their approach by saying, “Perhaps we could consider changing the way we do that”. By contrast, North Americans generally value competition and achievement and tend to be direct in their communication. Consequently, in making a request they might say, “I think we should change the way we do that.” The subjective worldview of a New Zealander who communicates indirectly might consider the American’s statement as rude or pushy. An individual’s subjective culture, ‘frame of reference’, or worldview influences communication. In this thesis, I use ‘worldview’ or ‘frame of reference’ to refer to an individual’s ‘subjective culture’.

The purpose of engaging medical students in online reflection and discussion was to examine their ability to recognise their own and others’ worldviews or frames of reference, including the values, beliefs, and norms that underpinned people’s behaviour in the clinical cases discussed. I explain this in greater detail in Chapter Three.

## **Ethnocentrism**

According to psychologist Donald Campbell and colleagues, ethnocentrism is a worldview in which one’s own way of doing things is viewed as ‘correct’ or ‘natural’ and the conduct or way of doing things in other cultures is viewed as ‘wrong’ or ‘unnatural’ (Brewer &

Campbell, 1976; Campbell & LeVine, 1968). People who have an ethnocentric worldview view the norms of behaviour, values, and roles in their culture as correct and think that their way of doing things is valid for everyone. They also behave in ways that favour their own group and are hostile toward other groups. In a medical context, a person with an ethnocentric perspective might perceive Western medical approaches as the only valid approach and view non-Western medical practices as ‘wrong’. Ethnocentrism is discussed in more detail in Chapters Three and Six, where I discuss the theories that underpinned my analysis of students’ intercultural sensitivity.

## **Dominant and non-dominant cultural groups**

As a result of immigration, New Zealand is a culturally plural society where groups of people, from different cultural backgrounds are not equal in power economically, politically or in terms of numbers of people (Berry, 1997). Societal power differentials are recognised in terminology such as ‘minority’ or ‘mainstream’. Following Berry (1997), in this thesis I use the term ‘cultural group’ to describe *all* groups of people and I use the terms ‘dominant’ and ‘non-dominant’ in reference to the relative power of a particular group.

## **Cultural competence vs intercultural competence**

The term ‘cultural competence’ is often used in medicine to refer to a clinician’s or system’s ability to serve clients from non-dominant cultural groups. There is much debate in the literature about what constitutes ‘cultural competence’ in medicine (Reitmanova, 2011). The following definition captures a multifaceted view of cultural competence:

Cultural competence in healthcare entails understanding the importance of social and cultural influences on patients’ health beliefs and behaviours; considering how these factors interact at multiple levels of the healthcare delivery system (e.g. at the level of

structural processes of care or clinical decision making); and finally, devising interventions that take these issues into account to assure quality healthcare delivery to diverse patient populations. (Betancourt et al., 2003, p. 297)

In my study, I use the term ‘intercultural’ competence, rather than ‘cultural’ competence to describe the ability to interact effectively with people from backgrounds different from one’s own. I chose “intercultural’ competence, because it implies competence ‘interacting’ with people who are different from oneself, rather than competence in understanding cultural ‘others’. I define intercultural competence as a “dynamic, on-going, interactive self-reflective learning process that transforms attitudes, skills and knowledge for effective and appropriate communication and interaction across cultures” (Freeman et al., 2009, p. 13). Intercultural competence is, therefore, framed as a lifelong learning process that involves reflection and on-going learning, rather than as an end point which can be reached.

For the purpose of this study, I have largely focused on culture in a narrow sense—in relation to the social and behavioural norms and the like, that may be associated with a particular national or ethnic identity. However, I recognise the value of a more expansive definition of intercultural competence in medicine that acknowledges the ability of individuals and systems to be responsive to patients from non-dominant cultural groups and different sub-cultures. Sub-cultures are sub-divisions within a national culture based on social factors such as socioeconomic status, spiritual beliefs, regional or rural/urban residence (Gordon, 1947) or physical factors such disability, age, gender, and sexual orientation/identity. I recognise that an individual can identify with different sub-cultures simultaneously, and, for example, in the context of a medical consultation being a disabled mother may be more germane to an individual’s health status than being a Chinese female (Durie, 2001).

## **Cultural humility**

The term ‘cultural humility’ was put forward as an alternative term to ‘cultural competence’ by medical professionals in 1990s and aimed to foster culturally responsive healthcare (Foronda, Baptiste, Reinholdt, & Ousman, 2016; Tervalon & Murray-García, 1998). Cultural humility involves an on-going “commitment to self-reflection and analysis, to redressing power imbalances in the physician-patient relationship, and to developing mutually beneficial, non-paternalistic advocacy partnerships with individuals and communities” (Danso, 2016, p. 12-13). Cultural humility stresses the importance of self-critique, an attitude of openness to learn from the patient, and mutual respect in the doctor-patient relationship in order to foster improved health outcomes for oppressed people (Kools, Chimwaza, & Macha, 2015). Hook and colleagues identified two components of cultural humility: intrapersonal and interpersonal (Hook, Davis, Owen, Worthington, & Utsey, 2013). The intrapersonal component involves being aware of our limitations to understand the worldview or cultural background of our patient. At the interpersonal level, cultural humility involves being other-oriented, which is characterised by respect and openness to the patient’s worldview. In this way, cultural humility is thought to foster an alliance between clinician and patient who work together to arrive at a beneficial outcome. Cultural humility is discussed in more detail in Chapter Two, the review of the literature and in my findings Chapters Five, Six and Seven.

## **Cross cultural vs intercultural communication**

There are two terms, cross-cultural and intercultural, that are commonly used to research culture and communication. I chose to use the term intercultural rather than cross-cultural. Intercultural communication research focuses on what happens in face-to-face communication between people of different national cultures (Gudykunst & Mody, 2002). For example, such research may explore what happens when a Japanese person initiates a

conversation in a New Zealand context or what differences in communication patterns may cause misunderstanding (Gudykunst & Mody, 2002). The term cross-cultural communication comes from cultural anthropology research that examines communication processes in different cultures and is largely comparative (Gudykunst & Mody, 2002). By contrast, this study focused on medical students' ability to notice intercultural differences in the ways doctors and patients/families from dissimilar cultural backgrounds interacted with one another, and how cultural differences might contribute to misunderstandings or miscommunication.

## **Intercultural Learning**

In the current study, medical students' process of reflection about the impact of culture in a medical context may involve intercultural learning. Intercultural learning is defined as "acquiring increased awareness of subjective cultural context (worldview), including one's own, and developing greater ability to interact sensitively and competently across cultural contexts" (Bennett, 2009, p. 52).

## **Asynchronous online discussion**

Asynchronous online discussion refers to a form of computer-assisted education in which the instructor and the students are separated by time and space (Andresen, 2009). This means that students and teachers can log on and engage with one another online at a convenient time for them (Bender, 2012). The asynchronous online environment also allows time for students to ponder ideas before responding (Curtis, 2006). Online discussions also provide a written transcript that students can revisit at any time (Andresen, 2009). Asynchronous online learning combined with the face-to-face tutorial is referred to a 'blended' or 'hybrid' learning. This study involved implementing an online component to a Culture and Health unit in second-year medicine. The advantages and



disadvantages of asynchronous online discussion are discussed in more detail in Chapter Two.

## The New Zealand context

Understanding the perspectives of the medical students in this study requires some understanding of the New Zealand cultural and medical context. Consequently, in this section, I briefly discuss New Zealand's cultural context and how it impacts on health and medicine. Before beginning, I want to clarify that Māori is the name of indigenous people of New Zealand and Aotearoa is the name for New Zealand in the Māori's language.

Medical practitioners in Aotearoa/New Zealand need to be able to treat patients from backgrounds different to their own for at least three reasons. Firstly, New Zealand has a unique bicultural heritage grounded in a Treaty (The Treaty of Waitangi/Te Tiriti o Waitangi) between Māori, and the British crown. Recognition of 'culture' and its significance is enshrined in New Zealand law. For example, currently the Ministry of Health sets out New Zealand's Māori Health Strategy, 'He Korowai Oranga', a framework that directs government and the health and disability sector to achieve positive health outcomes for Māori (Ministry of Health New Zealand, 2015). Secondly, the increasing diversity of the New Zealand population requires that doctors are able to effectively treat patients from different backgrounds. Thirdly, Māori, Pacific and other non-dominant cultural groups in New Zealand have significantly poorer health outcomes than dominant cultural groups. The reasons for disparities in health outcomes among non-dominant cultural groups in Aotearoa/New Zealand are complex; however, they are thought, in part, to be a consequence of the behaviours of health providers (Bacal, Jansen, & Smith, 2006; Baxter, 2002; Crengle, 2000). I explain these ideas more fully in the sections that follow.

## The Treaty of Waitangi and health

New Zealand's founding document, the Treaty of Waitangi (hereafter 'the Treaty'), was signed in 1840 by Māori and representatives of the British crown (Papps & Ramsden, 1996). The Treaty was intended to establish a partnership between Māori and the British Crown and protect the individual rights of both Māori and non-Māori in Aotearoa/New Zealand. However, the document was written in two different languages – Māori signed a Māori version of the document, and the British signed an English version. The subtle differences in meanings between the translations meant that both parties were essentially signing a different document (Orange, 2015), and from the perspective of Māori, although they theoretically had rights of British citizenship under the Treaty, the consequence was colonisation which resulted in the misappropriation and transfer of resources from indigenous people to new settlers (Robson & Harris, 2007). The ultimate result of this colonisation was pervasive loss of land, economic and social neglect for Māori, and a general disregard of Māori rights under the Treaty (Sullivan, 2003).

Following social unrest in the 1970s and 1980s, the relationship between the Treaty and the health of Māori was detailed in a set of principles written by the Royal Commission on Social Policy (Royal Commission on Social Policy, 1988). In regards to health, these guidelines required the Ministry of Health to involve Māori in Māori health policy and practice, and to fund Māori health initiatives in the provision of services (Papps & Ramsden, 1996). Te Reo Māori, the Māori language, was recognised as an official language of Aotearoa/New Zealand in 1987 (Te Puni Kōkiri, 2014), and many health workplaces now incorporate Māori language and codes of behaviour into their daily practices (Hera, 2013). More recently, the New Zealand Public Health and Disability Act of 2000, amended in 2010 (New Zealand Public Health and Disability Amendment Act 2010, 2011), preserved the relationship between the Treaty of Waitangi and health of Māori, and

required the Crown to develop partnerships with Māori and ensure responsiveness to Māori health needs (DeSouza, 2008).

Ongoing education of medical professionals on the Treaty and tikanga Māori (Māori codes of behaviour) within health workplaces and medical education underscores the importance of understanding the cultural practices of Māori in order to foster effective interactions (Hera, 2013). Despite these efforts, Māori continue to have significant and ongoing health outcome disparities compared with non-Māori (Robson & Harris, 2007). For example, Māori have shorter life expectancy by 8-9 years compared with non-Māori, and there is greater incidence of infectious diseases, major chronic illnesses and injuries among Māori than non-Māori (Harris et al., 2012). As noted, these disparities are thought to be, in part, due to doctor-patient interactions (Bacal et al., 2006; DeSouza, 2008).

## **Effective healthcare across cultures**

A clinician's competence relies heavily on effective communication; however, effective communication when patient and doctor are from different cultures depends on the doctor understanding the patient's cultural context and their view of illness (Bacal et al., 2006). A doctor may unintentionally make a patient feel awkward, uncomfortable or worse take offence because of differences in matters such as body language, privacy considerations and way of expressing agreement or disagreement (Bacal et al., 2006).

Patients can often feel apprehensive, uncertain or intimidated in medical settings and a breakdown in communication between doctor and patient can create additional obstacles to good care (McPherson & McNaughton, 2003). Doctors need to be aware of the sociocultural factors, including biases, their own and their patients', that influence health and healthcare (Beagan & Kumas-Tan, 2009). Prior research indicates that patient outcomes improve when physicians attend to the whole patient—that is, to their personal,

emotional and cultural concerns, and not just to biomedical concerns (Levinson, Gorawara-Bhat, & Lamb, 2000). Self-reflection can help doctors to be aware of sociocultural factors that influence health and healthcare (Beagan & Kumas-Tan, 2009). The rapidly changing demographics in New Zealand demand that doctors are increasingly able to treat patients from backgrounds different to their own.

## **New Zealand's changing demographics**

Changes in the ethnic, religious and linguistic diversity in Aotearoa/New Zealand provide a compelling reason for developing medical students' intercultural competence (DeSouza, 2008; Durie, 2001). Census data from 2013 reveals changes in the ethnic make-up of Aotearoa/New Zealand. The ethnic categories used in the census information, such as 'Pacific peoples' or 'Asian peoples', mask considerable diversity. For example, Pacific peoples hail from 22 different nations, each with their own language, culture and history (Hera, 2013). The same can be said for the Asian peoples category which includes Chinese from different regions of the world, Indians, Filipinos, Koreans, and more (Statistics New Zealand, 2013). Table 1 illustrates the ethnic breakdown of the Aotearoa/New Zealand population in 2013, and the ethnic population growth since 2006.

**TABLE 1 NEW ZEALAND POPULATION BY ETHNICITY**

Ethnicity	Percentage of total population	Percentage increase since 2006
European	74%	13.8%
Māori	14.9%	5.9%
Asian	11.8%	33%
Pacific	7.4%	11.3%
Middle Eastern, Latin American, and African	1%	35.1%

*Note.* Statistics New Zealand, 2013

Currently, the Māori and Pacific populations of Aotearoa/New Zealand are steadily increasing. Māori are expected to account for 22% of the population by 2051 (Durie, 2001). A high proportion of Māori (43.6 %) are under 20 years of age and more Māori children than Māori adults also identify with one or more other (non-Māori) ethnic groups (Statistics New Zealand, 2013).

In 2013, one in four New Zealanders were born overseas, and the most common overseas birthplace was Asia (Statistics New Zealand, 2013). The number of Asian New Zealanders doubled between 2001 and 2013 (Statistics New Zealand, 2013). Similar to Māori, a large proportion of Asian New Zealanders (30%) were aged 20-34 years. Pacific peoples, the fourth largest ethnic group in Aotearoa/New Zealand, accounted for 35.7% of all children, which was the largest proportion of children aged 0-14 years (Statistics New Zealand, 2013).

Reflecting the different ethnic groups residing in the country, many languages are also spoken in New Zealand. While English is the most commonly spoken language, Te Reo Māori is the second most common, and Samoan, third (Statistics New Zealand, 2013).

Between 2001 and 2013 the number of people speaking Hindi tripled, and the number of

people speaking northern Chinese languages (including Mandarin) nearly doubled (Statistics New Zealand, 2013). Hindi and Mandarin are now the fourth and fifth most commonly spoken languages respectively in Aotearoa/New Zealand (Statistics New Zealand, 2013). Language differences create communication challenges for physicians and make it increasingly important for physicians to know how to effectively work with translators (Gray, 2014).

### **Differential health outcomes among non-dominant cultural groups and the doctor-patient relationship**

Non-dominant cultural groups in New Zealand bear a disproportionate burden of disease. Social determinants of health such as unemployment, lack of education, disparity in access to and quality of care, as well as the social environment, are all factors that influence health disparities between non-dominant and dominant cultural groups in New Zealand (Robson & Harris, 2007). Of these, quality of care and the social environment are particularly relevant to the doctor-patient relationship and are pertinent to the current study.

Disparities in the quality of care received by non-dominant cultural groups in Aotearoa/New Zealand result in poor health outcomes. Prejudice and stereotyping by physicians can influence the quality of care in the form of poor diagnosis and treatment of patients from non-dominant cultural groups (Green et al., 2007; van Ryn & Burke, 2000). For example, Māori have fewer referrals and diagnostic tests such as diabetes and ischemic heart disease screening and treatment (Robson & Harris, 2007). Māori also have shorter appointments with primary care physicians and are offered and prescribed less pain relief during labour and less treatment of specialist services such as physiotherapy (DeSouza, 2008).

Lack of education and the social environment can also affect the quality of healthcare (Krieger, 2001; Robson & Harris, 2007). People with lower levels of education may find it difficult to navigate the health system (Robson & Harris, 2007) and may feel their thoughts will not be heard or respected (Collins & Rocco, 2014). This can limit a patient's sense of having choices and control over his or her treatment options (Krieger, 2005). Some patients may be reluctant to discuss the health or wellness issues they face in their communities or at home, because they fear their healthcare provider will be judgemental of them (Collins & Rocco, 2014).

### **Educational and legal mandates to address health disparities**

Differential health outcomes among non-dominant cultural groups in Aotearoa/New Zealand have resulted in educational and legal efforts to reduce health inequities. These efforts are aimed at promoting culturally competent care that is patient-centred, respectful, and takes the patient's individual preferences, needs and values into account when making clinical decisions (Dogra, Reitmanova, & Carter-Pokras, 2009). Some examples include the Nursing Council of New Zealand's inclusion of 'cultural safety' in the nursing curriculum, the Health Practitioner's Competence Assurance Act, 2003, and the New Zealand Medical Council's 2006 Statement of Cultural Competency.

The Nursing Council of New Zealand (NCNZ) introduced 'cultural safety' into nursing and midwifery curricula in 1992 (DeSouza, 2008; Papps & Ramsden, 1996) to address historic inequities in health outcomes for Māori and other non-dominant cultural groups (Gray, 2014). 'Cultural safety' was defined at that time as, "the effective nursing of a person/family from another culture by a nurse who had undertaken a process of reflection on [their] own cultural identity and recognises the impact of the nurse's culture on [their] own nursing practice" (Papps & Ramsden, 1996, p. 491). In 2005, the Nursing Council of

New Zealand introduced Guidelines (Nursing Council of New Zealand, 2005) and in 2011 they released Standards of Practice for Culturally Competent Nursing based on concepts of social justice (Douglas et al., 2011). These 12 standards provide guidance on clinical practice, research, education and administration of nursing with the aim of reducing inequalities in health outcomes. Standard 2 refers to Critical Reflection and states that “Nurses shall engage in critical reflection of their own values, beliefs and cultural heritage to have an awareness of how these qualities and issues can affect culturally congruent nursing care” (Douglas, 2011, p. 318). It is not surprising that reflection is ranked highly among standards of practice given that the first aspect of cultural safety education focuses on nurses “understanding self as a cultural bearer; the historical, social; and political influences on health; and development of relationships that engender trust and respect” (Nursing Council of New Zealand, 2011, p. 5)

Legal mandates for cultural competence among health practitioners included the Health Practitioners Competence Assurance Act (HPCAA) (Ministry of Health, 2003) that set standards of clinical competence, cultural competence, and ethical conduct for all health practitioners. In addition, the New Zealand Code of Health and Disability Consumers’ Rights also contains references to culture, such as “Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori” (Health & Disability Commissioner, 1996).

In response to legislative mandates, professional and accreditation bodies have incorporated requirements for cultural competence into the practice and training of medical doctors. The New Zealand Medical Council published a Statement of Cultural Competence (Medical Council of New Zealand, 2006) that explains what is expected of doctors in Aotearoa/New Zealand with respect to cultural competence. Similarly, the



Australian Medical Council (AMC) (2012), which accredits medical programmes in Australia and New Zealand, calls for cultural competence training for medical students (Australian Medical Council Ltd, 2012; Yorke, 2013).

In response to legal mandates and professional accreditation requirements, the university where this study was conducted has included cultural competence training in their undergraduate medical education programme. The Culture and Health unit in second-year medicine, in which my study was conducted, is only one part of the curriculum to develop cultural competence in the University's medical graduates. Students complete a year-long health science curriculum prior to competitive entry into second-year medicine. Thus, second-year medicine is the first year of the medical programme.

Placement of the Culture and Health unit in the first year of the professional medicine programme speaks to the value of introducing cultural competence early in the students' medical training. However, the challenge remains of how to interest medical students in the topic of culture in healthcare when their primary focus is on learning biomedical knowledge. My study aimed to explore the effectiveness of online discussion to engage medical students in reflection on topics related to culture in medicine.

## The research setting

This research was conducted in 2012 at the University of Otago (UO) School of Medicine, the oldest of the two institutions in Aotearoa/New Zealand that confer undergraduate medical degrees. The students who participated in the study were enrolled in the Bachelor of Medicine and Bachelor of Surgery (MBChB), an undergraduate medical degree programme. The medical students are admitted via competitive entry following a one-year Health Science First Year program (Faculty of Medicine, 2011). The first two years of the MBChB programme, Early Learning in Medicine (ELM, years 2-3), are taught on the main

UO campus, located in Dunedin. In years 4-5, students are divided into three cohorts and study at one of three UO campuses: Dunedin, Christchurch, or Wellington. Year 6 can be completed at hospitals outside Dunedin, Christchurch, or Wellington (Faculty of Medicine, 2011).

In 2012, the study was conducted in the Culture and Health unit. This unit sat within the Healthcare in the Community course, and was one of three year-long modules in ELM - Integrated Cases, Clinical Skills and Healthcare in the Community (HIC) - that are taught alongside the medical sciences (Faculty of Medicine, 2009). The Healthcare in the Community course aimed to develop students' understanding of patients in a healthcare context, and explored concepts such as "the patient-doctor relationship, the subjective experiences of illness, the patient's personal context (e.g. family, culture, beliefs, etc.), chronic illness, end of life issues, and becoming a doctor (e.g. developing resilience, practicing safely), etc" (Faculty of Medicine, 2014, p. 4).

## Overview of the thesis

The remainder of this thesis is organised as follows. In Chapter Two, I review the literature on reflection. I consider the components of reflection, the purpose of reflection in medical education, and the criticisms and dilemmas associated with teaching, facilitating and assessing reflection. I also discuss the relationship between reflection and the development of intercultural competence, and the literature on using online learning to facilitate learning about culture.

In Chapter Three I discuss the theoretical frameworks that underpinned my analysis of students' online reflection. Firstly, I further clarify the constructivist definitions of culture and intercultural learning that informed my study. Next, I describe the concept of meaning perspectives (Mezirow, 1990, 1991, 1998, 2000) and their relationship to intercultural

learning. I then discuss the important part that reflection and dialogue play in interrogating meaning perspectives, and how the social constructivist nature of online learning can support reflection and intercultural learning. Finally, I describe the ‘Intercultural Development Continuum’ (Bennett, 1986, 1993; Hammer, Bennett, & Wiseman, 2003) that was used to evaluate students’ intercultural sensitivity in the online posts.

Chapter Four provides an overview of the research process, including an explanation of my methodological approach and the rationale for using an interpretive qualitative research approach. I describe the ethical approval process, recruitment of the participants, a description of the student cohort, and how I collected and managed the data. I then explain the reflective framework and Intercultural Development Continuum I used to analyse the students’ levels of reflection and intercultural sensitivity respectively. I also discuss how I addressed trustworthiness and ethical considerations in this research.

In Chapters Five through Seven I present the findings of this study. In Chapter Five, I provide an overview of the different levels of reflection in the students’ online posts. I also highlight some challenges associated with evaluating reflection. In Chapter Six, I analyse the students’ intercultural sensitivity observed at different levels of reflection and draw attention to the differences in how students at different levels of reflection noticed and understood cultural differences depicted in the intercultural clinical cases. Finally, I describe how reflective students applied new understandings about culture to their future practice as doctors.

In chapter Seven, I explore the factors that facilitated or hindered online reflection in this study. I include an analysis of the ways in which the online learning environment both promoted and limited students’ reflection and intercultural learning, highlighting the crucial role that tutors played in facilitating or hindering students’ online reflection. Finally, I explain how the design of the online activity and the public nature of the online

environment may have influenced the quality of students' reflection and students' willingness to reflect.

In Chapter eight I summarise the key findings of the study and link these findings to the existing literature. I explain the contributions this study makes to the literature on developing intercultural sensitivity and competence. I discuss the study's implications for facilitating intercultural reflection online and identify some of the limitations of the study. I conclude with some recommendations for future research.

# Chapter Two

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## Literature Review



## Introduction

This chapter provides an analysis of the relevant academic literature on reflection and intercultural competence. I first clarify what is meant by reflection, including a description of different components and hierarchical levels of reflection, as well as common conceptions of reflection such as ‘reflective practice’. Included in this section is a discussion of the debates and dilemmas associated with teaching, facilitating and assessing reflection. Secondly, I discuss why reflection is important in medical education. Then I explore the relationship between reflection and intercultural competence and the use of reflective activities to facilitate intercultural learning in healthcare. Next, I explore the benefits and challenges of the online environment as a site for intercultural learning. I then highlight what we know about students’ reflective thinking when learning about culture, and discuss the challenges associated with facilitating intercultural learning. I end by outlining the gaps in the literature that this study seeks to address.

Any discussion of reflection or reflective practice is fraught with challenge, because of the complexity and confusion surrounding the term ‘reflection’. Many different fields of study, including education, social work, healthcare and others, use the term reflection or reflective practice drawing upon different theoretical traditions and different frames of reference (Kember, McKay, Sinclair, & Wong, 2008). The term ‘reflective practice’ popularised by Donald Schön (1983) in *The Reflective Practitioner*, is often referred to in the literature with the assumption that everyone understands what it is (Kember et al., 2008); however, others suggest that there is a lack of conceptual clarity about what is meant by ‘reflective practice’ (Kinsella, 2010; Thompson & Thompson, 2008). In this literature review, I seek to clarify my conception of reflection, and provide a context for my exploration of the relationship between students’ levels of reflection and the development

of medical students' intercultural competence, by reviewing the literature that is most relevant to the current study.

## **An overview of reflection**

Foundational theorists such as Dewey, Habermas, Mezirow and Schön have promoted the importance of reflective thinking for learning generally, and for professional practice. Schön's (1995) notion of the 'reflective practitioner' built on the work of Dewey (1933) and identified the important role of reflection in developing knowledge and theory in professional practice. Schön's work has been widely used in many professional practice settings such as nursing, medicine and social care. Critical reflection involves questioning the assumptions that underpin one's thoughts and beliefs, as well as questioning the power relations that underpin professional practices (Brookfield, 2000, 2009; Mezirow, 1991; E. W. Taylor, 2007, 2008). Critical reflection developed out of the critical social theory of Habermas (1971) and Freire (1970) and influenced Mezirow (1991) and others who viewed critical reflection as central to transformative and emancipatory learning.

Reflection in academic and professional settings is a demanding, complex mental process that involves a stated or conscious purpose (Moon, 2007), and is thought to enhance learning and improve professional practice (Ryan & Ryan, 2013). It takes time and practise for students to engage in reflection in deep and meaningful ways (Moon, 2007; Rogers, 2001). Some argue that reflection can be taught (Bain, Ballantyne, Mills, & Lester, 2002); however, others point out that students' conceptions of knowledge will influence their ability to engage in reflection (King & Kitchener, 1994; Taylor, 1994).

I draw upon Nguyen, Fernandez, Karsenti, & Charlin's (2014) theory-informed conceptual model of reflection as a framework to share my understanding of reflection. Nguyen et al. (2014) based their conceptual model on the outcomes of a systematic review of reflection



literature in the learning, professional practice and medical education literature published between 2008 and 2012. I find their model useful in bringing together key components that together provide clarity about what reflection entails.

## Components of reflection

The five components of reflection have to do with the content (what you think about) and the process (how you think about) that leads to a thinking process that in turn becomes reflection (Nguyen et al., 2014). Firstly, reflection is a complex, purposeful thinking process that is focused on thoughts (e.g. knowledge, ideas) and/or actions (e.g. experience) (Moon, 1999; Nguyen et al., 2014; Wear, Zarconi, Garden, & Jones, 2012). An individual reflects on an experience, a feeling, or a concept in order to think about it in more depth and detail—this involves “some degree of elaborating on or interrogating” of that experience, feeling or concept (Wear, Zarconi, et al., 2012). Often reflection is triggered by a dilemma or a puzzling situation that does not appear to have an immediate or obvious solution (Clift, Houston, & Pugach, 1990). Dewey (1933) described reflection as caused by “a state of doubt, hesitation, perplexity, mental difficulty in which [reflective] thinking originates” and as involving “searching, hunting, inquiring, to find material that will resolve doubt, settle and dispose of the perplexity” (pp. 13-14). Consequently, reflection is a purposeful thinking process that focuses on thoughts or actions that are complicated or unstructured and may not lend themselves to an obvious solution (Moon, 1999; Nguyen et al., 2014).

The second component of reflection has to do with the process of reflection, which is attentive, critical, exploratory, and iterative (Nguyen et al., 2014). Reflective thinking is more than just recall or description (Moon, 1999); instead it involves careful attention to an idea or experience, examining it from different angles “like turning over a stone, putting

ideas together and seeing relationships” (Dewey, 1933, p. 57). In this way reflection is not a linear process; it often draws upon prior knowledge and experience to make sense of the puzzling situation or concept (Boud, 2001; Wear, Zarconi, et al., 2012). Dewey (1933) viewed reflection as a process of ‘making sense of the world’ and believed reflection involved “careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it” (p.6). Implicit in Dewey’s definition of reflection is the notion of critique. Others stress the exploratory nature of reflection and stress that one reflects on or explores an experience or concept to learn from it (Boud, Keogh, & Walker, 1985; Boyd & Fales, 1983). Emotions can also play an important role in reflection and can influence the way one perceives and interprets events (Boud et al., 1985; Harrison, Lawson, & Wortley, 2005; Poldner, Simons, Wijngaard & van der Shaaf, 2012). Thus, emotions can encourage or inhibit learning from an experience (Boud et al., 1985).

The third component of reflection involves interrogating the conscious or unconscious conceptual frames, or structure of assumptions, that underlie one’s thinking and actions (Brookfield, 1995; Mezirow, 1991; Nguyen et al., 2014). Reflection involves becoming aware of how these frames of reference influence “why we perceive, think, feel or act as we do” (Mezirow, 1991, p.108), and critical reflection involves questioning the validity and accuracy of those assumptions (Brookfield, 2000; Mezirow, 1991). This component of reflection is especially relevant to the current study, which examined the students’ ability to reflect on and critique their frame of reference, or way of viewing the world, acquired through socialisation. Are they able to recognise how their frames of reference or assumptions influence the way they understand and interpret their experience? Thus reflection in this study is focused on students becoming aware of their own understanding of an experience or problem (Eva & Regehr, 2008).

The fourth component of reflection involves ‘a view on change’ or transformation in the form of thoughts (the meaning you make) or actions (the things you do) and relates to why one engages in reflection (Nguyen et al., 2014; Wear, Zarconi, et al., 2012). Boyd and Fales (1983) argue that reflection “creates and clarifies meaning” and “results in changed conceptual perspective” (p. 100). In other words, reflection is a process of making sense of a situation or concept that results in a change in how one conceives of or perceives a situation and can potentially influence one’s future actions.

The fifth component of reflection has to do with the ‘self’ and relates to the Latin root of the word reflection, ‘flexio’, which means ‘bending back’ (Nguyen et al., 2014). What this means is that the ‘meaning making’ or understanding that a student achieves as a result of reflection is related back to the self. Reflection is a process that “creates and clarifies meaning in terms of self” (Boyd & Fales, 1983, p. 100).

To summarise, reflection is a thinking process that focuses on thoughts and actions in a way that is attentive, critical, exploratory and iterative, and examines underlying conceptual frames with a view on change (e.g. transformed thoughts and/or actions) that is related back to the self (Nguyen et al., 2014). Students reflect on an idea or experience in order to clarify the meaning they can take from it. Reflection in academic or professional settings, such as this study, is purposeful and should indicate learning and growth of professional knowledge (Ryan, 2013).

As noted earlier, critical reflection involves interrogating the underlying assumptions of one’s thoughts and beliefs and examining the wider social context and power relationships (Brookfield, 2009; Mezirow, 1991, 2009; Taylor, 2008). Critical reflection can lead to learning that involves viewing a situation or oneself in a new and different way, such as recognising power relationships or developing awareness of agency to change oneself or society (Mezirow, 2009; Taylor, 2008; Thompson & Pascal, 2012). Critical reflection

involves asking questions, exploring cause and effect relationships, challenging bias, contrasting theory with practice, and recognising systemic issues (Ash & Clayton, 2009). Through a process of challenging “simplistic conclusions, inviting alternative perspectives, and asking ‘why’ iteratively”, critical reflection can deepen learning (Ash & Clayton, 2009, p. 27). When critical reflection results in changed perspectives, transformative action can result.

Transformative action can be a different way of doing or saying something, or it can be a new attitude or change of thinking, such as critically questioning the power relationships within medicine and how they influence experiences and interactions between doctors and patients (Wear, Zarconi, et al., 2012). Reflection in medicine that is transformative focuses on thoughts and actions, and moves students away from self-absorption and toward a “recognition of the need for ethical action, such as taking a risk, redressing a wrong, or at the very least resolving to do things differently next time” (Wear, Zarconi, et al., 2012).

Wear, et al. (2012) argue that an essential aspect of reflection that leads to transformed actions is recognising that reflection is as much a social practice as a solitary one.

Reflection is a process of both looking inward to oneself and outward towards others (Wear, Zarconi, et al., 2012). According to Dewey (1944), it is important that reflection happens in a community. Dewey argued that we must clarify our ideas in order to communicate them to others, and in sharing our ideas we allow them to be scrutinised by others, revealing the strengths or weaknesses in our thinking. Through a social process one is able to see alternative perspectives and sharpen one’s own thinking (Brookfield, 1995). More will be said about reflection as a social practice later in this review where I discuss reflection to improve professional practice.

However, reflection as a social process “requires attitudes that value the personal and intellectual growth of oneself and others” (Rodgers, 2002, p. 845). This study drew upon a

social process to involve students in online reflection with classmates about intercultural interactions between doctor, patients and families. The use of reflection among peers was intended to encourage consideration of multiple perspectives on the intercultural clinical cases discussed and thereby promote deeper reflection (see Chapter Four on my methodological approach).

## **Vertical aspect of reflection**

The literature on reflection also refers to hierarchical levels of reflection, where deeper levels of reflection indicate higher quality (Biggs, Kember, & Leung, 2001; Grossman, 2008; Ryan & Ryan, 2013). At the surface levels, reflection usually involves a description of an experience or concept, or the recognition of feelings, with little or no analysis. At the deeper levels, it involves the questioning of assumptions and more critical analysis (Boud et al., 1985; Mezirow, 1991). The deeper levels of reflection are more difficult to achieve and typically happen less often (Kember et al., 2008; Mann, Gordon, & MacLeod, 2009). However, with teachers' feedback and scaffolding of reflective tasks, students can be supported to move to deeper levels of reflection (Grossman, 2009; Ryan, 2013).

## **Reflective practice**

Another concept that is significant in the reflection literature is the concept of 'reflective practice' (Kinsella, 2010). Developing students' reflective practice has become a hallmark of many professional programmes, including medicine. Reflective practice is thought to be most relevant when practitioners are confronted with ambiguous or uncertain situations, such as intercultural consultations. Reflective practice is relevant to my study, so I briefly describe it here.

Building on the work of Dewey (1933), Schön (1983; 1995) proposed a new way of thinking about professional practice, coining the term ‘reflective practice’. Schön did not view professionals as merely ‘instrumental problem solvers’ who apply scientific or technical knowledge to solve problems. Rather he argued that professionals engage in a kind of artistry that interweaves ‘thinking and doing’ to develop knowledge and theory through a process of reflection-in-action and reflection-on-action. *Reflection-in-action* is akin to ‘thinking on your feet’ and is used to develop a solution when one is carrying out a puzzling task that is not easily dealt with using expert knowledge. *Reflection-on-action* involves looking back at an experience to try to understand what can be learned and how the learning can be applied to future practice (Schön, 1983). Ideally reflection-in-action and reflection-on-action are iterative and interconnected so that they inform each other (Thompson & Thompson, 2008).

Schön’s theory overlooked another important aspect of reflection. This aspect involves *reflection-for-action*, or anticipatory reflection, that one engages in prior to taking action (Greenwood, 1998; Ong, 2011). Reflection-for-action is important in medicine as it provides an opportunity for doctors to think through what they want to do and develop a plan of action, especially in cases where the patient may have a condition that the doctor is unfamiliar with (Ong, 2011). In the current study, students engaged in reflection-for-action about treating patients who come from backgrounds different to their own.

The concept of reflective practice is important to this study because it helps us appreciate the value of reflection as a means to cope with difficult or ambiguous situations, learn from them, and apply that learning to future practice (Kember, 2008; Schön, 1987, 1995). Intercultural medical consultations can create ambiguous and challenging situations because the doctor and patient/family may have different expectations or understandings about the illness or treatment plan. Through reflection-for-action, doctors can prepare to

work with patients from cultures different from their own by learning more about the values, beliefs and worldview of people from those communities and becoming aware of the values and belief that guide their behaviour (Gray, 2014). If a consultation is not going well, reflection-in-action can help the practitioner to consider other perspectives (e.g. those of the patient or their family) that may differ from their own, identify possible courses of action and evaluate the efficacy of their actions for future practice. In this way, reflective practice provides a means of learning and improving practice through a process of reflection.

## Defining reflection in this study

This study explores medical students' ability to critically reflect on intercultural interactions in a medical context, consider different perspectives and potential challenges, and think through the implications for their future practice. In doing so, in this study I define reflection as:

A careful examination and analysis of thoughts, actions and feelings related to the doctor and patient/family interactions depicted in course readings and documentary film, resulting in new understandings that are interpreted in terms of self and/or personal experience, or future practice (adapted from Kember et al., 2008; Nguyen et al., 2014; Reitmanova, 2011).

The purpose of online reflection and discussion in this study was to create an opportunity for students to create and clarify meaning related to the impact of cultural differences in doctor-patient interactions, to examine their own and others' worldview (Berger & Luckmann, 1967; Triandis, 1994), and to explore how new insights could inform their future practice as doctors.

## Why is reflection important in medical education?

There are three general purposes for using reflection in medical education (Sandars, 2009).

The first is the use of reflection to deepen learning in academic, online, or practice-based settings. The second purpose of reflection is to develop the therapeutic relationship between doctor and patient. The third is to develop a reflective capacity to support ongoing professional practice and life-long learning. All three purposes relate to this study.

### Reflection to improve learning

Reflective activities are used to deepen learning. They do this by encouraging students to make sense of new information and connect it to prior knowledge and experience (Moon, 2007). Students who are focused on ‘understanding’ are thought to take a deep approach to learning as opposed to a surface approach (Marton & Säljö, 1976). According to Entwistle (1997), students who use deep approaches to learning want to understand course material for themselves, look for underlying meaning and identify patterns and principles. Deep approaches to learning are used by students who are reflective and evaluate evidence with caution and criticality. By contrast, students who use surface approaches to learning focus on course requirements and view course material as a set of discrete and unrelated facts that must be memorised and reproduced for assessment. These students are typically non-reflective and struggle to understand new ideas.

Understanding is the key element that connects reflection with deep approaches to learning (Kember, 2008). The desire to understand is what characterises a deep approach, and reflection is triggered by the need to understand an issue or problem (Leung & Kember, 2003). Prior research in health professions demonstrates a relationship between deep approaches to learning and reflection. Leung and Kember (2003) used two measures to explore a relationship between approaches to learning and types of reflection.



Undergraduate students from all years of a health science programme ( $n=402$ ) completed the Revised Study Process Questionnaire (Biggs et al., 2001) and the Reflection Questionnaire (Kember et al., 2000). Leung and Kember (2003) found that a surface approach correlated with habitual action, the lowest level in the reflection questionnaire ( $r = 0.65$ ), and deep learning approaches were correlated with the three upper levels of reflection: understanding ( $r=0.33$ ), reflection ( $r = 0.49$ ) and critical reflection ( $r = 0.50$ ). Their results indicated a relationship between approaches to learning and reflective thinking (Leung & Kember, 2003). Sobral (2001) also examined the relationship between measures of reflection and students' approaches to learning. He examined how medical students: 1) approached their learning; 2) perceived the learning outcomes; and 3) achieved academically. Findings from this study support a positive relationship between reflection and deep learning. Leung and Kember's (2003) research supports the use of reflective activities in medical education to develop students' reflective capacity and encourage deeper understanding.

## **Reflection to improve professional practice**

Reflective capacity is now widely recognised as an important professional competency in medicine, and as a result is now an expected outcome in medical education accreditation schemes (Hera, 2013; Yorke, 2013). Reflection is not only important for effective patient-centred care, but also plays a role in accurate clinical decision making, lifelong learning and personal well-being as a clinician (Reis, Wald, Monroe, & Borkan, 2010). Reflection is also crucial to work effectively in interprofessional healthcare teams (Barr, 2013; Clark, 2009; Khalili, Orchard, Spence Laschinger, & Farah, 2013).

Rapid developments in medical science and technology mean that physicians are confronted with complex, scientific, ethical and moral concerns that are difficult to

navigate (Kinsella, 2010). Reflection is essential to help professionals cope with these challenges. For example, doctors are expected to engage in safe and appropriate care, which requires keeping their knowledge and skills up-to-date (Kinsella, 2010). Complexity, be it scientific, ethical or moral, requires that one can reflect on their performance, evaluate their thinking and problem solving, and incorporate insights to improve their practice (Mann et al., 2009).

Mamede and Schmidt's (2005) quantitative study looked at the correlation between doctors' reflective practice and the amount of time they had been practising medicine. Their findings indicated that the use of reflective practice varied among doctors, but that reflection was especially important when dealing with clinical cases that were complex and difficult to diagnose. Reflection appeared to be a factor in improving accuracy and minimising diagnostic errors. From a professional perspective, the purpose of reflection is to develop habits of mind that encourage critical reflection on one's decisions in support of best practice and ongoing learning, as well as flexibility and humility in the practice of medicine (Black & Plowright, 2010; Epstein, 1999; Lachman & Pawlina, 2006).

Reflection is also valuable when working in interprofessional teams. Clark (2009) and Barr (2013) discuss the distinction between first-order and second-order reflection. First-order reflection involves focusing on one's own personal views especially from the vantage point of one's own profession (Barr, 2013; Clark, 2009). Whereas, second-order reflection involves a 'decentring' or stepping back and examining our own frame of reference, how we are viewing a situation from a particular perspective vis a vis alternative perspectives. This second-order reflection occurs when doctors are learning in a community, with and from other allied professionals. This second-order reflection can help doctors to recognise the narrowness of their own professional perspective and become aware of perspectives of

other allied professions in order to facilitate collaboration and teamwork and improve outcomes for patients (Khalili et al., 2013; Pollard, Miers, & Rickaby, 2012).

## **Reflection to improve doctor-patient relationships**

Reflection is also central to the doctor-patient relationship and patient-centred care in that doctors must be able to critically evaluate evidence not only from their perspective, values and beliefs, but also those of their patients' (Wald, Davis, Reis, Monroe, & Borkan, 2009). To do this, doctors need to develop self-awareness of their own beliefs, attitudes and values, and also recognise the values of the professional culture in which they work (Epstein, 1999). Reflection provides a vehicle for developing this self-awareness (Epstein, 1999).

In order to effectively collaborate with a patient from a different background, the doctor must both understand their own culture and perspectives, and be able to elicit information that helps them to understand the patient's perspective (Betancourt & Green, 2010; Dogra, Reitmanova, & Carter-Pokras, 2009; Kleinman, 1988). These skills are crucial to establish and maintain a therapeutic relationship in order to successfully treat their patients (Gray, 2014). This can be especially challenging in intercultural therapeutic relationships because of differences in values, beliefs and experiences between the doctor and their patient, family, or caregivers (Sandars, 2009). People's ideas about health and well-being and how one stays healthy or gets well following illness are culturally influenced (Kagawa-Singer & Kassim-Lakha, 2003). Culture can also impact effective communication, shaping a person's willingness to express disagreement, body language and feelings about issues like modesty (Bacal, Jansen, & Smith, 2006). A patient-centred approach requires that the doctor solicit information in order to understand the patient's preferences, needs and expectations

regarding their health or illness, and make clinical decisions based on this information (Dogra et al., 2009).

A starting place for medical students to develop the skills to successfully navigate intercultural therapeutic relationships is to reflect and identify their own beliefs and values (Sandars, 2009) or, at the very least, recognise that others may hold different values and beliefs to themselves (Fitzgerald, 2000). Students need to understand how personal, social and economic factors have influenced their beliefs and attitudes, and have the opportunity to challenge stereotypes and examine their own biases (Gregg & Saha, 2006). It is important for students to recognise how their own perceptions influence their practice, and realise that the way they interpret an experience, interaction, or response is affected by what they are looking for and their prior knowledge and experience (Fook & Askeland, 2006). This is especially relevant in intercultural interactions where it is easy to make assumptions based on one's own personal experience, and not recognise that the patient might view the interaction, illness or treatment plan very differently.

Guided reflection with a mentor or through discussion with peers can be useful to challenge students' beliefs and assumptions and provide alternative perspectives (Lie, Shapiro, Cohn, & Najm, 2010; Sandars, 2009). For example, in Lie et al.'s (2010) study that combined individual written reflection with facilitated peer discussion to explore issues associated with intercultural healthcare and healthcare disparities, findings indicated that the medical students changed their thinking about the doctor-patient relationship. Students realised: 1) the importance of a more mutual and horizontal relationship in which they got to know the patient; 2) how language barriers could impede their ability to develop rapport with their patients; 3) the importance of establishing trusting relationships with patients and understanding their perspectives in order to come up with treatment plans that the patients would adhere to; and 4) the importance of facilitating positive physician-patient

interactions through listening, being open-minded, and avoiding stereotypes. These findings resonate with the current study, which seeks to better understand the relationship between students' reflective thinking and intercultural learning about their beliefs, values and attitudes through the process of reflection and online discussion about intercultural interactions depicted in selected clinical cases.

## **Dilemmas associated with teaching, facilitating and assessing reflection**

The literature on reflection reveals a number of criticisms that relate to how reflection is taught or facilitated, the time required for reflection, challenges inherent in the assessment of reflection, and the inappropriate use of reflection. Some scholars criticise online reflection, suggesting that it threatens students' autonomy. It is important to consider these criticisms in order to ethically and responsibly engage students in reflective activities, as this study sought to do.

Some scholars criticise the ways in which reflection is taught. On one hand, highly structured approaches to reflection can lead students to a focus on 'recipe following' rather than making their own meaning from an experience (Boud & Walker, 1998; Smith, 2011; Aronson, 2011). On the other hand, personal forms of reflection that stress 'reflexivity' (i.e. an individual looking back at themselves) can lead students to be overly critical of themselves if the teacher does not properly scaffold the reflective activity (Boud & Walker, 1998). Students need a context for engaging in personal forms of reflection, otherwise there is the danger that they can slip into self-conscious, self-absorbed, or isolated thinking (Boud & Walker, 1998; Finlay, 2002). Finlay (2002) suggests that personal insights are not an 'end in themselves' but should lead to wider interpretations or general applications. In addition, tutors should encourage students' thinking by asking open ended questions and

be facilitators of learning rather using a didactic teaching approach (Trede & Smith, 2012).

In order to address this, tutors need to help students connect personal reflections on experience with conceptual frameworks, intended learning outcomes, or professional practice concepts in the discipline (Boud & Walker, 1998; Usher, 1985 in Moon, 1999).

Some scholars also assert there is the potential for reflection to be used as a method of control—that it can become form of negative self-regulation (Macfarlane, 2015; Ross, 2012; Smith, 2011). For example, some scholars suggest that if students are asked to ‘critically’ examine their personal understanding, knowledge and skills, without clear definitions of what is meant by ‘critical’, they may feel compelled to focus on the negative aspects of their performance in order to demonstrate their learning and professional development (Ross, 2011; Smith, 2011). In addition, students who value silence as a means to learning may not be comfortable with public self-disclosure inherent in online reflection (Jin, 2012). Others suggest that requiring students to reflect online violates their personal autonomy and reinforces performativity (Macfarlane, 2015). Clegg (1999) argues if ‘reflective practice’ constitutes a compulsory component of professional programmes where professional autonomy is not respected, it can become a highly prescriptive, self-monitoring exercise that is used to ‘normalise’ practice rather than change practice. In this way, reflection can become “part of a system of surveillance whereby professional competence is judged in terms of compliance with practices that the practitioner feels powerless to change” (p. 173). To counter an atmosphere of surveillance and compliance, tutors need to create a respectful relationship that stresses reciprocity in sharing experience and modelling reflection (Bearman & Molloy, 2017; Trede & Smith, 2012). “Students who feel respected will think aloud with their tutor and engage in a dialogue that will help them gain insights and help them gain clarity in developing their practice skills” (Trede & Smith, 2012, p. 625)

According to Ross (2011), online reflection often involves many common approaches used in written reflection offline; however, there are unique challenges inherent in the online environment that can conspire to undermine the intended purposes of reflection. Firstly, the public nature of online reflection can leave students uncertain about whether their stories and experiences are legitimate (Hargreaves, 2004). This means that students may be less likely to be candid and be more strategic in presenting their thoughts and experiences (Ross, 2011). Secondly, digital representations of oneself are transitory (e.g. editable, non-material) but they are meant to represent a “stable, autonomous self” (p. 121), which raises the question of how to ensure a safe space online where students trust one another to be honest about who they are and what they think. Thirdly, there are tensions between students need to be authentic and the “market-driven discourse of the personal brand” associated with an online presence (p. 122-23). These issues need to be carefully considered as one embarks on engaging students in online reflection.

Another challenge is the time and effort required for students to engage in reflection and for teachers to provide feedback, which can be problematic in a discipline such as medicine. Scholars agree that examining one’s own practices or assumptions is personally demanding, and asking students to consider and explore alternative perspectives takes time (Bolam, Gleeson, & Murphy, 2003; Lincoln, Stockhausen, & Maloney, 1997, Smith, 2011). Smith (2011) says that students may feel this type of activity takes time away from learning disciplinary knowledge and skills, which medical students may consider more important. In addition, teachers require time to read and provide feedback on reflection (Gray & Tobin, 2010). In order to maximise effectiveness, students must be discerning about the material they will reflect on in order to save time and focus their energies (Boud et al., 1985), and teachers need time allotted to providing feedback to students (Gray & Tobin, 2010).

Assessment of reflection also generates significant debate. Boud (2001) explains there is an inherent tension between assessment and reflection. In an assessment, students are supposed to demonstrate what they know and be judged on what presumably is their best work. By contrast, “reflection involves a focus on uncertainty, perplexing events, and exploration without necessarily knowing where it will lead” (p. 16). In the case where students are asked as part of the reflective learning process to articulate their doubts, and share about things they do not understand or do not know, assessment can be seen as problematic (Boud, 2001; Boud & Walker, 1998). This dilemma illustrates the inherent power issues associated with high-stakes assessment of reflection and how such assessment may conflict with “discourses of authentic self-knowledge, personal and professional development, the improvement of practice and transformative learning” (Ross, 2011, p. 113). Clearly, students are more likely to censor their reflections and say what they think the teacher wants to hear rather than question and explore areas of uncertainty in their thinking when reflective exercises are assessed (Boud & Walker, 1998; Ma, 2010).

Despite the challenges associated with assessing reflection, scholars argue that there are good reasons to consider assessing reflection. Some scholars in professional programmes believe it is important to evaluate students’ reflections in order to determine if they are developing reflective ability, especially with respect to students’ reflections on case notes (Boud, 2001; Kember et al., 1999; Plack, Driscoll, Blissett, McKenna, & Plack, 2005; Wald, Borkan, Scott, Anthony, & Reis, 2012). In addition, students tend to value what is assessed, so if reflective activities are not assessed, students may think reflection is less important (Pee, Woodman, Fry, & Davenport, 2002). Others argue that assessment is a driver of learning and for this reason reflection should be assessed (Aronson, 2011). The



current study sought to analyse students' reflective thinking in the online discussions for the purposes of research, but not for a mark (see Chapter Four, Methodology).

## **Addressing the dilemmas of teaching and facilitating reflection**

Acknowledging and understanding the challenges associated with facilitating reflection is necessary in order to address them (Brookfield, 2017; Fook, 2010); Fook, 2010). If reflection is to be used effectively in professional contexts, its use needs to be well structured in ways that are practical, meaningful and encouraged by the organisation (Fook, 2010). Boud and Walker (1998) stress that teachers need to consider the broader context in which reflection will occur and be aware of existing power relations. For example, the teacher has a dominant position relative to the student, so teachers need to consider whether the reflective activity reinforces their position of authority, or genuinely allows students to question or contradict them. Boud and Walker (1998) also argue that teachers need to be aware of the larger sociocultural, political or institutional context in which the reflective activity takes place; consider how to prepare students to question existing power structures within the institution or society; and determine how they will respond or provide feedback.

Scholars interested in the use of reflection in educational contexts argue that educators need to consider many aspects prior to using reflection as a learning activity with their students. These aspects include: 1) how they will prepare themselves and students for reflection (Perlman, Ross, Christner, & Lypson, 2011); 2) how they will create a context for reflection that is conducive to learning (Boud & Walker, 1998); 3) what types of activities they will use; and 4) how they will create a safe environment for reflection so that students can create personal meaning from their reflection (Aronson, 2011). Finally, teachers need to think about how they will provide feedback on students' reflection (Wald et al., 2009),

whether they will assess their students' reflection, and if so, how students' reflection will be assessed (Boud, 2001).

The literature that highlights the potential challenges associated with using reflection to foster learning does not necessarily suggest that reflection should be abandoned as an educational device (Fendler, 2003; Ross, 2011). Rather, it provides a series of cautions to bear in mind when using reflection in teaching. This study represents my belief in the educational value of students engaging in reflective activities, as long as reflective activities are approached in considered and ethically responsible ways (see above). Moreover, reflective ability is not only an important competency for medical practitioners, it is also crucial for developing intercultural competence (Fitzgerald, 2000; Tervalon & Murray-García, 1998), as discussed in the following section. Therefore, engaging medical students in reflective activities about intercultural interactions in medical education is crucial.

## **Reflection and intercultural competence: exploring the linkages**

### **Components of intercultural competence**

Before I discuss the linkages between reflection and intercultural competence, I want to clarify components of intercultural competence described in the literature. I then explain the links between these components and reflection. A summary of recent reviews of the literature on intercultural competence reveals that the characteristics of cultural competence fall into three domains: 1) intercultural traits; 2) intercultural attitudes and worldviews; and 3) intercultural capabilities (Leung, Ang, & Tan, 2014).

First, intercultural traits are long-lasting personal characteristics that influence a person's common behaviours in intercultural encounters or contexts (Leung et al., 2014).

Intercultural traits include such things as open mindedness (Van der Zee & Van Oudenhoven, 2000), tolerance of ambiguity (Bird, Mendenhall, Stevens, & Oddou, 2010; Deardorff, 2006), flexibility (Matsumoto et al., 2001; Van der Zee & Van Oudenhoven, 2000), and inquisitiveness, etc. (Bird et al., 2010).

Second, according to Leung et al. (2014), intercultural attitudes and worldviews refer to the way a person perceives other cultures that are different from their worldview. An individual may have positive or negative attitudes toward their interactions with other cultures. These attitudes reflect different cultural worldviews—either ethnocentric (i.e., sees the world and the actions of others from their own worldview) or a worldview that recognizes contradictions and complexities of different cultures and countries (Bennett, 1986, 1993), as well as similarities that exist beyond surface-level differences (Leung et al., 2014). A person who is highly culturally competent construes cultural differences and similarities in more complex ways rather than in simplistic, ethnocentric ways (Bennett, 2004; Leung et al., 2014). Worldviews are discussed in detail in Chapter Three, where I explain the theories used to analyse the data in this study.

Third, intercultural capabilities stress what people do to be effective in intercultural encounters (Earley & Ang, 2003). These capabilities include such things as demonstrating knowledge of other cultures or countries (Earley & Ang, 2003; Javidan & Teagarden, 2011) or adapting one's communication (Lloyd & Härtel, 2010). Earley & Ang (2003) propose three capabilities or types of cultural intelligence: 1) metacognitive (i.e., mental ability to acquire and comprehend cultural knowledge; 2) motivational (i.e., ability to direct and maintain energy to function in intercultural encounters; and 3) behavioural (i.e., ability to adapt behaviour for effective intercultural interaction). Leung & Cheng (2014) describe 'cultural tuning' as the ability to maintain a holistic concern for all parties, collaborate and learn in intercultural encounters (Leung & Cheng, 2014).

## Linkages between reflection and intercultural competence

Reflective capacity is implicit in the cognitive, attitudinal and emotional skills associated with intercultural competence (Blasco, 2012). Firstly, metacognitive skills associated with intercultural competence include self-analysis and ‘critical cultural awareness’ (Byram, 1997), cultural self-awareness (Deardorff, 2011), mindfulness (Gudykunst & Kim, 2003; Nagata, 2004), self-reflexivity (Nagata, 2004), and an awareness of the impact of culture on behaviour (Bird et al., 2010). Metacognitive skills contribute to one’s ability to “suspend attachment to one’s own perspective and/or try to see things... from another’s perspective” (Blasco, 2012, p. 477), and adapt one’s communication (Ting-Toomey, 2007) and actions (Blasco, 2012) in order to increase the possibility of reaching a mutually acceptable outcome for all involved (Stone, 2006). Secondly, attitudinal qualities that relate to reflection and intercultural competence include the ability to cope with ambiguity that can characterise intercultural encounters and open-mindedness, flexibility, and a willingness to suspend judgement in order to see another perspective (Bennett, 1986, 1993; Blasco, 2012; Deardorff, 2006). Thirdly, emotional competencies are important because they can influence one’s behaviour; these competencies include understanding the origin and implications of one’s own feelings, and coping with the feelings of uncertainty, frustration, and anger that can be triggered in intercultural situations (Byram, Talkington, & Lengel, 2007; Jackson, 2011; McAllister, Whiteford, Hill, Thomas, & Fitzgerald, 2006; Stier, 2006). For example, in a study of nurses working with immigrant patients across 14 healthcare services in Canada and a teaching hospital in Australia, one participant observed that anxiety and fear of making a mistake “got in the way of listening and interacting with [clients]” from different backgrounds (Fuller, 2003, p. 788). The ability to be aware of one’s emotions and their impact on interactions with patients can assist one to develop effective coping strategies.

## Reflection and intercultural competence in medicine

The medical literature also describes the close connection between reflective capacity and the development of intercultural competence (Dharamsi, 2011; Lie et al., 2010; Reitmanova, 2011; Tervalon & Murray-García, 1998; Wear, Kumagai, Varley, & Zarconi, 2012). Medical students use reflective processes to recognise their own cultural perspective (Wear, Kumagai, et al., 2012) and to identify their own values, biases, and assumptions (Kumagai & Lypson, 2009). Reflection also assists medical students to be aware that they bring unconscious, internalised perspectives based on prior experience to their interactions with patients (Wear, Kumagai, et al., 2012). This is important because a medical student's experience and perspectives may differ significantly from their patient's and contribute to misunderstanding and miscommunication.

Scholars argue that at the heart of the doctor-patient interaction across cultures is the need for good reflective self-awareness (Fitzgerald, 2000; Fuller, 2003; Gilbert, 2006), an attitude of openness to the patient's perspective (Gilbert, 2006; B. Gray, 2014; Kleinman, 1988), and a willingness to learn (Cooke, Irby, & O'Brien, 2010; Fuller, 2003; Gilbert, 2006). DeSantis (1994) suggests that when a doctor is working with a patient from a culture different from their own, they need to be aware of dual ethnocentrism (i.e. in themselves and their patient), noting that there are three cultural contexts at work: the doctor's culture, the patient's culture and the culture of the healthcare organisation. In this cultural context, Gilbert (2006) argues it is important that the doctor engage the patient in a dialogue in order to reveal how the patient understands their illness (i.e. explanatory model), and recognise how the doctor's own values and the values of the organisation can influence their delivery of care (Fuller, 2003).

Some scholars suggest that rather than cultural competence, which implies mastery of a large body of knowledge with respect to cultural differences, what is needed is 'cultural

humility', a "lifelong commitment to self-evaluation. . . and redressing power imbalances in the patient-doctor dynamic" (Ramsden, 1993; Tervalon & Murray-García, 1998, p. 117).

Cultural humility requires critical thinking skills and the ability to reflect on practice (Schuessler, Wilder, & Byrd, 2012). It also involves recognising one's prejudices and misperceptions with respect to culture, challenging power imbalances in work relationships and organisations, and developing an attitude of 'not knowing' in order to learn from the patient (Abell, Manuel, & Schoeneman, 2015; Fisher-Borne, Cain, & Martin, 2015).

Similarly, Fuller (2003) proposes that medical care across cultures should be a 'negotiated reflective practice', which first involves an openness to learning about the beliefs and values held by the patient, and the patient's expectations. Secondly, it involves self-awareness of one's own and the organisation's beliefs and values. Finally, negotiation takes place when the needs of all three—doctor, patient, and organisation—are taken into consideration. Fuller (2003) acknowledges there can be barriers to negotiation. For example, patients may defer to the doctor; the patient may not view themselves as a free agent (e.g. due to religious beliefs), and the healthcare worker may not be able to do what the patient requests (e.g. re-suture the mother's labia following birth of a baby). However, the limitations of negotiation can be expressed in ways that demonstrate mutual respect and help the patient retain some decision-making power (e.g. let the pregnant mother know, in advance of baby's delivery, what the doctor and hospital will and will not do). The potential ambiguity in an interaction between doctor and patient from different backgrounds may be best met with reflective awareness of one's own biases and beliefs, as well as power imbalances and an attitude of openness to understand the patient's identity and needs (Fuller, 2003).

## **The use of reflection for intercultural learning in a healthcare context**

Reflection is not only a crucial aspect of culturally responsive care, but is also frequently used as a strategy to facilitate and document intercultural learning following clinical and overseas placements (Lie et al., 2010; McAllister et al., 2006; Roberts, Sanders, Mann, & Wass, 2010; Schuessler, Wilder, & Byrd, 2012b). Written reflection compels students to clarify their ideas (Vygotsky, 1978), and demonstrate what they have learned from an intercultural interaction, simulation, overseas experience, or case-based learning experience (Deardorff, 2011; McAllister et al., 2006; Reitmanova, 2011; Wilbur, 2016).

Reflective journaling combined with active engagement in service learning or clinical placement is a powerful method to deepen students' intercultural learning and develop reflective thinking skills (Rubin, 2004). Journaling gives students time to reflect back on an experience and evaluate how the experience has affected them. For example, a U.S.-based study with 50 nursing students in a four-semester low-income clinical placement used reflective journaling to document the development of cultural humility. The researchers found that early on students realised that their culture was not the only one and that culture played an important role in the lives of their patients (Schuessler et al., 2012). Students often begin their intercultural learning by examining and appreciating their own worldview before appreciating other worldviews (Liaw, 2008; Whiteford, 1998). Nursing students in Schuessler et al.'s (2012) study saw how poverty contributed to healthcare disparities and power imbalances. They recognised that they needed to develop trusting relationships with patients if they were going to be effective nurses. By the end of the placement, students had shifted from thinking about 'what to do to patients', to 'how they could best meet the patients' needs'. The authors contend that combining first-hand experience along with reflection can over time assist students to learn cultural humility and help them understand and begin to address healthcare disparities.

Reflective journals are also a useful tool in medical education when used with curricular content addressing cultural diversity in medical contexts. For example, Crandall, George, Marion, & Davis (2003) used reflective journals following videos, panel discussions, and interviews of community members, and found that the reflective journals provided a means for students to respond to ideas presented in class and think through their practical application with patients. In addition, reflective journals have been shown to provide a space for students to recognise the negative impact of stereotyping and how assumptions about particular groups can lead to adverse effects in clinical decision making (Boutin-Foster, Foster, & Konopasek, 2008).

A combination of individual written reflection and peer group discussion can be especially effective in promoting reflection and intercultural learning (Lai & Land, 2009). For example, in a two-year U.S.-based study, a total of 188 students in 23 rotations (6-12 students per rotation) participated in a four-week clerkship in family medicine (Lie, Shapiro, Cohn, & Najm, 2010). The researchers combined written reflection and facilitated peer-discussion following clinical placement to improve medical students' ability to identify and respond to intercultural and health disparity issues. They found that the use of individual written reflections allowed students to organise their thoughts and impressions, while teacher-facilitated peer group discussion encouraged students to see different perspectives and to challenge one another's assumptions and expectations, which increased their learning. My study combined individual written reflection with group discussion online. I turn now to a consideration of online learning environments and intercultural learning.



## How is intercultural learning fostered online?

At the outset, I acknowledge that online learning is a dynamic and changing educational domain. For example, in the years since this study was conducted, there has been an increase in the use of mobile devices, such as smart phones, iPads and portable computers in education and a growing recognition that learning is ‘ubiquitous’ or can occur anytime or anywhere (Bender, 2012; Hwang & Tsai, 2011). Furthermore, the use of social networking in an education context has proliferated with the use of blogs, wikis, pod casts, Twitter and more (Miller, 2014). There are also websites devoted to exploring new forms of teaching and learning with technology such as Hybrid Pedagogy <http://hybridpedagogy.org/risk-event-based-pedagogies/> and Field Notes for 21<sup>st</sup> Century Literacies/ HASTAC.

Despite the preponderance of studies that explore the efficacy and use of online learning (Akyol & Garrison, 2014; Bender, 2012; Means, Toyama, Murphy, Bakia, & Jones, 2010; Miller, 2014), many studies rely on students’ self-reports or student satisfaction using technology and some are not well grounded in theory (Rourke & Kanuka, 2009; Wang & Vásquez, 2012). Consequently, there is disagreement and uncertainty about the quality of students’ learning in the online environment (Akyol & Garrison, 2014; Rourke & Kanuka, 2009). Despite the debates, there is growing interest in the use of online technology in health professional education (Thomas, 2013). The asynchronous environment allows busy students and clinicians to study at the pace and time that suits the competing demands of their clinical work (Thomas, 2013).

Initially, I considered using blogs to engage students in discussion about the intercultural cases. However, after discussions with the course coordinator, I realised that both students and tutors were novices to online learning. I decided that using an online discussion forum

in Moodle, the course management system, would be challenging but more manageable than blogs for the participants in this study.

I chose online discussion as a learning medium for this study because of: 1) its potential to encourage reflective thinking in medical students; and 2) its ability to foster peer learning among a diverse group of medical students about issues related to culture in medicine. The online learning environment has unique characteristics that encourage reflection and higher order thinking in students (Bender, 2012; Garrison, 2003; Levine, 2007). In addition, online learning is thought to support peer learning through dialogue and interaction (Swan, 2005). Here I explore the literature that discusses both the benefits and challenges of the online learning environment for fostering reflection and peer learning. I then consider a few studies that have examined students' online reflection for intercultural learning in non-medical contexts.

The asynchronous and interactive nature of online learning is thought to encourage higher-order thinking and reflection (Akyol & Garrison, 2014). The time lapse involved in an asynchronous learning environment allows time for students to reflect on and organise their ideas before posting, which can make online discussion more thoughtful and reflective than face-to-face discussion (Curtis, 2006; Ma, 2010). Bender (2012) suggests that blended learning—that is the combination of the face-to-face tutorial/classroom along with the asynchronous online environment—capitalises on 'concrete experience' and 'reflective observation' aspects of Kolb's (1984) experiential learning cycle. In the tutorial students can 'experience' a movie or reading and plan, and the asynchronous online environment provides time and space for reflection and conceptualisation—the two latter stages in the Kolb's cycle. In a study that examined the processes and practices of reflective thinking among HIV/AIDS educators in an online environment, Curtis (2006) found that when classmates questioned the meaning of postings made by peers, the

asynchronous environment allowed time for students to rethink, re-examine and reframe the issue before responding. Online discussion arguably provides a productive time lapse between questions or comments and responses, allowing critical reflection to occur (Curtis, 2006).

Akyol & Garrison (2011) explain that asynchronous online learning combines reflection (or internal thought processes) with interaction (or collaboration with others) and brings together “private and public worlds” to create meaning (p. 4). Online discussion encourages reflection as students share ideas, summarise and build upon what others have said, and revise statements that are misunderstood (Lai & Land, 2009). Furthermore, feedback from peers can foster reflection as students encounter ideas that differ from their own (Plack, Dunfee, Rindfleisch, & Driscoll, 2008), which in turn forces students to negotiate meaning as they resolve differences (Lai and Land, 2009). In order to come to a common understanding students may “explain concepts to each other, defend their own views, ask thought-provoking questions, hypothesise, [and] speculate about alternative interpretations” (Lai & Land, 2009, p. 147). This process of trying to understand and be understood is central to reflection online (Curtis, 2006).

Online discussion also encourages reflection by making thoughts and feelings transparent through students’ written arguments and changes in thinking as they respond to one another (Ziegahn, 2005). Online discussions provide a record of students’ intellectual and emotional reactions as they consider new ideas, so that students are able to reflect on what others have said, their own reactions, and make connections with past experience in order to formulate new perspectives and learning (Ziegahn, 2001).

The online learning environment is also thought to foster peer learning as students construct knowledge through a dialogic process (Swan, 2005). Social constructivists hold that learning is a social process in which students construct meaning through

communication and interaction with peers or experienced others (Swan, 2005) and take responsibility for their own learning (Sthapornnanon, Sakulbumrungsil, Theeraroungchaisri, & Watcharadamrongkun, 2009). The teacher's role online should be one of facilitator rather than instructor, with an emphasis on knowledge construction rather than knowledge transmission (Garrison, 2011; Guo, Chen, Lei, & Wen, 2014). Research findings from an introductory online professional practice course in pharmacy, found that engaging students in authentic tasks (e.g., visits to drug companies), combined with meaningful online assignments that included individual reflection and group work, helped students negotiate meaning and solve problems online (Sthapornnanon et al., 2009). Plack et al. (2008) initiated an online component for students to share a critical incident in a final-year physiotherapy placement. Students felt the online collaboration helped them gain insights that would not have been possible without the interaction with peers online. The online environment can encourage peer learning as students formulate their ideas or clarify what they do not understand, negotiate meaning and develop new understandings through discussion with peers (Laurillard, 2009). In the current study, the online environment was intended to provide a space for students to grapple with, and improve their understanding of, the complexity of cultural issues in a medical context.

Social constructivists stress the value of students bringing their own life experience, beliefs, values, and attitudes to the learning process (Sthapornnanon et al., 2009; Swan, 2005). For example, in a U.S.-based online postgraduate course on inclusive community building, Ziegahn (2001) found that reflective students drew upon and reinterpreted their personal experience in light of theoretical concepts introduced in the course. The process of exploring how cultural values influenced verbal and non-verbal behaviour prompted students to view their culture in new ways, or in some cases recognise that they actually had a culture, where before they thought they were devoid of one. Similarly, online

interactive journal writing used to stimulate reflection can be a personal process in which the students integrate academic, personal, and professional life experience, connect educational content to practice, evaluate practice and consider changes for their future practice (Andrusyszyn & Davie, 1997; Lee, 2010). In the current study, the diverse backgrounds of the medical students were expected to enrich the online discussions and provide different perspectives as students grappled with the cultural dimensions evident in the clinical cases under discussion.

### **What are the challenges of online discussion?**

Despite the apparent benefits of online discussions mentioned here, there are also challenges that can potentially undermine the benefits of online learning (Swan, 2005). Online discussions may fall short of their potential to stimulate higher order thinking and reflection for a variety of reasons (Lai & Land, 2009). The reasons include the structure and design of the activity (Garrison & Cleveland-Innes, 2005), the questions asked of students (Arnold & Ducate, 2006; Guldberg & Pilkington, 2007), the challenge of reflecting in a public space (Ross, 2012), and guidelines about length and timeliness of posts (Pawan, Paulus, Yalcin, & Chang, 2003). Unstructured discussions can lead students to merely engage in courtesy talk or describe or report on events or issues rather than engaging in critical reflection and analysis, examining causal factors, or making connections between theory and practice (Hibbard, Bellara, & Vermette, 2010; Jones & Ryan, 2014). In a study that examined the type of student interactions that occurred online in four distance education courses (Garrison & Cleveland-Innes, 2005), findings indicated that students' interaction online did not equate with learning. Furthermore, both the design of the online activity and the teacher's facilitation of discussion played crucial roles in moving students beyond 'serial monologues' in which they shared personal opinion or experiences without connecting them to course content. In addition, teachers need to be clear about what is

expected of students, allow for both individual and collaborative activities, and make sure assessments are congruent with the learning goals (Garrison & Cleveland-Innes, 2005).

Arnold and Ducate (2006) examined online interaction in two foreign language methodology courses conducted in two US universities and found that the topics and questions asked greatly influenced students' cognitive involvement. Most posts were at the lower cognitive levels of identification, exploration and integration of ideas, and only a few posts reached the highest level of resolution that involved identifying and testing possible solutions. However, when students were explicitly asked to come up with a solution, more discussions reached resolution level—the highest cognitive level. Pawan et al. (2003) assert that it is important to provide clear guidelines about length of post, as well as expectations related to content and timeliness of posts in order to facilitate productive discussions.

Kanuka, Rourke, & Laflamme (2007) found that activities need to be: 1) well structured; 2) ensure students have clearly defined roles and responsibilities (e.g. moderator or summariser); and 3) use debate to encourage students to confront others' opinions.

Interestingly, Gilbert and Dabbagh (2005) discovered that confining the online discussion to course readings and asking students to limit the length of their posts diminished the quality of students' posts in terms of making meaning and making inferences. This was because students were confined to only drawing upon course readings and felt they couldn't express complex ideas in short posts.

Creating a supportive online community that is conducive to reflective dialogue is challenging (Kling & Courtright, 2003). In DiMauro and Gal's (1994) study of an online discussion set up for science teachers, there was scant evidence of reflective postings.

These authors proposed that students may have been reluctant to share postings about personal issues because of the public nature of the online environment. They concluded

that private or ‘bounded groups’ that are closed to others are necessary for students to feel comfortable to share topics of a personal nature.

Finally, scholars suggest that the teacher plays a crucial role in facilitating online discussion that moves students to deeper levels of reflection. The teacher is essential in modelling, monitoring and assessing reflection in order to increase the likelihood that students will reflect (Szabo & Schwartz, 2011). The role of facilitator involves commenting on students’ posts, raising questions, and directing the discussion in such a way as to facilitate reflection (Swan et al., 2008). This kind of reflection includes not only identifying an issue or problem, but also exploring possible solutions in light of theory and with reference to practice (Jones & Ryan, 2014). Some authors suggest that students can be taught to fulfil the role of facilitator online (Garrison et al., 2000). However, others assert that the instructor is necessary to introduce information, pose questions, model reflective thinking, and scaffold students’ reflection throughout the discussion to ensure students reach the deeper levels of reflection (Jones & Ryan, 2014; Swan et al., 2008). Jones and Ryan (2014) provide suggestions on how to scaffold students at each level of reflection and argue that if students do not progress through each level of reflection they cannot reach the deeper levels in which students apply insights to future practice.

### **How might online dialogue foster intercultural learning?**

In this section, I first discuss the literature on the use of online learning to engage students in language learning and dialogue about cultural diversity to develop intercultural competence. Following this, I review studies from outside a medical context that examined students’ reflective thinking and emotional reflection related to issues of race and cultural diversity, but not in a medical context (Zembylas, 2008; Ziegahn, 2005).

The online learning environment is increasingly being used to link students in different parts of the world to promote language learning and the development of intercultural competence. For example, Black (2008) investigated English language learners participation in online fan writing communities. Black found that the fan writing community provided opportunities to use English in an informal context that resulted in increased second-language proficiency as well as self-efficacy. Other studies have shown that participation in online diaspora spaces allows English language learners to use different linguistic modes and expressive forms to participate in global and local social networks (Lam, 2004; Thorne, Black, & Sykes, 2009). Liaw (2008) used e-forums to give English as a Foreign Language (EFL) learners the opportunity to engage with native speakers of English. The online interaction had a dual purpose; firstly, to gain practice using the target language with native speakers and secondly, to allow the EFL learners to act as cultural informants. The intention was that in the mediator role, students would gain a better understanding of their own culture as they described it to others of a different culture (Hager, 2005). Qualitative analysis of the online forum indicated that, during the online interaction, the students demonstrated several intercultural competencies. These competencies included an interest in describing their own culture and an understanding of other people's cultures, the ability to change perspectives, and insights into communication processes of both cultures, as well as intercultural communication processes in general.

Despite these positive findings, other research suggests that it can be difficult to engage students from different cultures in online intercultural dialogue. Bali (2014) examined intercultural dialogue online between university students in the U.S. and Arab countries and discovered the limitations of interactive online dialogue as a learning strategy. Bali (2014) found that, despite the fact that dialogue is viewed as an ideal in the West, students from the Arab world were disadvantaged because of their lack of familiarity and comfort



with interactive teaching and learning methods. In addition, dialogue primarily took place in English, and students who had less facility with English felt limited in their ability to express their ideas. Another important consideration is that students' ability to recognise different worldviews, grasp the different arguments in a discussion, and see the value of discussing contentious topics, is influenced by prior intercultural experience and maturity (Bali, 2014; Zieghan, 2001). For example, Muslim students from the Middle East who viewed homosexuality as taboo did not want to discuss the topic, in contrast to a U.S.-educated Muslim student who was more open to discussing homosexuality (Bali, 2014). Similarly, in Zieghan's (2001) study that examined how graduate students discussed cultural differences in an online course about inclusive community building, students who were from non-dominant cultural backgrounds, or who had significant overseas experience, were more reflective in discussing topics such as discrimination and racism.

Despite the challenges inherent in online dialogue, prior research suggests that the online environment can support and foster reflection about cultural difference and intercultural interactions (Zembylas, 2008; Ziegahn, 2001, 2005). The written, narrative, and asynchronous quality of the online environment provides time to reflect and space to express one's personal thoughts, analyse issues and discuss them with others (Akyol & Garrison, 2011; Andrusyszyn & Davie, 1997; Ziegahn, 2001, 2005). Zeighan (2001) found that the time lapse associated with asynchronous online discussion gave students time to think and consider the difficult emotions that came with examining social justice issues and students' own assumptions. Similarly, Zembylas (2008) found that the online environment during a year-long course provided a safe space for students to explore difficult emotions associated with cultural diversity and discrimination. Students' ability to reflect improved due to sustained reflection and their ability to empathise increased, helping them to develop a deeper understanding of others' experiences.

## What do we know about students' reflective processes while engaged in intercultural learning?

I now examine what we know about students' reflective processes as they engage in intercultural learning both on and offline. A few studies have specifically examined students' reflective processes as they experienced different cultures or explored cultural differences, but outside of medical contexts (Taylor, 1994; Wilbur, 2016, 2017; Zembylas, 2008; Ziegahn, 2001, 2005). This body of research suggests that students bring both reflective and non-reflective approaches to learning about cultural differences both on and offline (Taylor, 1994; Ziegahn, 2005). Ziegahn (2005) examined postgraduate students' reflective processes in online discussions in a postgraduate course on building inclusive communities. Students who used non-reflective approaches tended to minimise or ignore cultural difference as a way to avoid the unsettling feelings that arose when discussing cultural diversity and social justice issues. For example, one student briefly discussed their preconceptions about racial differences only to quickly affirm 'celebration' of diversity. Another student asserted that communication would always happen despite intercultural communication differences. Students who used non-reflective approaches viewed cultural difference as a threat, even though they valued cultural diversity and social unity (Ziegahn's 2005). By contrast, students who used reflective approaches were able to tolerate the ambiguity and go beyond their comfort zone to explore unsettling feelings that came with exploring cultural differences and perspective shifting. This supports the literature on reflection and intercultural competence that suggests that an inability to cope with difficult emotions can impede new intercultural learning (Boud et al., 1985; Taylor, 2000).

Taylor's (1994) investigation of US 'study abroad' students' development of intercultural competence found that students used both non-reflective and reflective approaches towards their overseas experiences. The majority of participants in Taylor's study used

non-reflective approaches, rarely questioning their values or assumptions. Non-reflective students, who experienced the unsettling feelings that come with living in a new culture, did not question their 'taken-for-granted assumptions' and did not relate assumptions to their challenging experiences abroad. Instead, these students carried on in the face of frustrations and believed that "thinking about the problem would only slow them down" (Taylor, 1994, p. 170). By contrast, reflective students showed a willingness to embrace difficult emotions and move through discomfort to examine their own values and beliefs (Taylor, 1994; also see, Zieghnan, 2005). Similarly, Zieghnan (2005) found that reflective students seemed better able to cope with the ambiguity that comes with the complexity of culture. These findings suggest that a reflective approach to intercultural learning requires a willingness to step outside one's comfort zone in order to question beliefs and values, and this typifies a deeper reflective approach (Taylor, 1994; Zembylas, 2008; Ziegahn, 2005).

Ziegahn (2005) conducted a mixed methods study examining Master's students' critical reflection on cultural differences in an online course on community development in multicultural populations. She found several behaviours were common in reflective students. Firstly, reflective students often used positioning statements to clarify their cultural identity and provide a starting point for their discussion about cultural difference. For example, "I'm a middle-class White Anglo-Saxon and all my dealings reflect this" (Ziegahn, 2005, p. 54). Secondly, reflective students were able to suspend judgement, rethink their underlying assumptions, question their responses to the theories presented, and consider alternative perspectives. Thirdly, students who entered the course with prior intercultural experience, or who were themselves from non-dominant or marginalised communities, appeared to come with established reflective habits. These students were able to reframe issues under discussion and link them to prior experience; they also appeared better able to grapple with emotional complexity than their less experienced

peers. In his study, Taylor (1994) described this as ‘setting the stage’, or students’ coming to the intercultural experience with a readiness to learn.

Wilbur (2016, 2017) conducted a study which used complementary, overlapping frameworks for reflection (Lyons, 2010) and intercultural competence (Bennett, 2009) to guide students through a travel course intended to develop intercultural competence through a reflective inquiry approach. Wilbur (2017) explains that the value of developing intercultural competence through a reflective inquiry approach is that students can apply a way of thinking that draws on experiential evidence to examine and critique social and political contexts with the aim of interacting more effectively and appropriately in different cultural contexts. In the process of examining patterns of behaviour in public and private spaces across cultural contexts, and consulting with local scholars, the students became aware of their own situated perspective or positionality. Students realised the cultural, social and political characteristics that influenced each perspective or position. Three themes that emerged from students’ reflective assignments were: 1) noticing (e.g. differences in proximity between people at cafes); 2) seeing things differently (e.g. initial observations were questioned by local scholars, which helped students to consider alternative explanations for behaviours and examine the contextual dimensions of people’s actions more carefully); and 3) seeing within and among others (e.g. students saw themselves, individually and as a group, differently as result of insights gained about the host country). A study conducted 18 months after the course ended, indicated that the reflective inquiry process (Lyons, 2010) and Bennett’s (2009) intercultural competence model formed a scaffold for continued intercultural learning over time (Wilbur, 2016).

From the studies described above, it is evident that intercultural learning involves examining oneself in relation to others, exploring deeply held values and beliefs, which in turn can trigger strong emotions. The findings from these studies raise important

considerations for tutors who are asked to facilitate intercultural learning, as was the case in my study.

### **What are the challenges inherent in facilitating intercultural learning?**

People who facilitate discussions about cultural differences require specific skills. Roberts, Sanders, Mann, and Wass's (2010) study of medical students' learning about cultural differences engaged in a work-based experience, found that reflection followed by discussion with peers supported students' intercultural learning, and that students enjoyed learning about culture with peers. However, students also reported that the rich cultural resources within the student group were not fully used, because students were reluctant to discuss sensitive issues. For example, students were too timid to ask fellow students wearing hijabs (Muslim head coverings) about their ideas regarding abortion, because they doubted the teacher's skill and interest in facilitating discussions about cultural difference.

The fact that cultural differences can be difficult to discuss raises important considerations for tutors. Tutors themselves need to be reflective and able to facilitate reflection in their students (Hatton & Smith, 1995). They also need to value the importance of learning about cultural difference and be prepared to facilitate discussions that explore sensitive topics related to deeply held values, biases, beliefs, and assumptions (Roberts et al., 2010). Tutors must be able to pose questions that encourage students to reflect on their personal values (Ziegahn, 2001) and foster an environment in which students feel safe to examine their own perspectives and identities in relation to other students', their patients', and tutors' (Dogra et al., 2009; Ma, 2010). Such teaching requires a less hierarchical, student-centred learning environment that emphasises mutual respect, collaboration, and participation, where students take responsibility for their own learning, and teachers are in a role of co-collaborator (Kumagai & Lypton, 2009; Reitmanova, 2011).

As discussed here, online discussions have been used successfully to foster intercultural learning (Bali, 2014; Liaw, 2008). However, only a few studies have explicitly examined the reflective processes that students use as they learn about themselves as cultural beings and consider the impact of intercultural interactions (Taylor, 1994; Wilbur, 2016, 2017; Ziegahn, 2001, 2005). I have not found published research that has examined students' reflective thinking as they learn about the impact of culture in a medical context. This is surprising given that reflection is frequently mentioned as an important component of intercultural competence in medicine (for example, see Fitzgerald, 2000; Kumagai & Lypson, 2009; Reitmanova, 2011; Wear, Kumagai, et al., 2012). This study addresses this gap by evaluating medical students' reflective thinking in online discussions and examining what students' levels of reflection reveal about their intercultural sensitivity—that is, their ability to notice and analyse cultural differences and identify adaptive responses for effective interaction.

## Summary

In this chapter, I have provided a context for the current study by reviewing the relevant literature. In the first section, I introduced the five components of reflection as well as the concepts of 'reflective practice' and critical reflection, and defined reflection in relation to this study. In the second section, I explored the three main purposes of reflection in medicine. In the third section, I addressed the dilemmas associated with teaching, facilitating, and assessing reflection. In the fourth section, I discussed the relationship between reflection and intercultural competence in general, and in a medical context, as well as the use of reflection to foster and document intercultural learning. In the fifth section, I discussed the benefits and challenges of using the online learning environment for encouraging students' reflection and intercultural learning and reviewed what is known about students' reflective processes when they learn about culture online. Finally, I

explored the pedagogical challenges associated with facilitating students' reflection about cultural difference.

The intercultural competence literature reinforces the importance of reflection not only to foster intercultural learning but also to document it (Deardorff, 2006). Some scholars suggest that reflective ability is inherent in intercultural competence (Fitzgerald, 2000). Several studies have examined students' reflective thinking as they learn about cultural difference and develop intercultural competence (Taylor, 1994; Wilbur, 2016, 2017; Zembylas, 2008; Ziegahn, 2001, 2005), but not in a medical context. This study addresses this gap and examines medical students' online reflection as they learn about themselves as cultural beings and about intercultural interactions in a medical context.

The study has important implications for facilitating reflection and intercultural learning in medical students. Firstly, the study sheds light on the characteristics of reflective students as they increase their intercultural sensitivity—that is, their ability to notice cultural differences, analyse their impact, and suggest strategies for effective interaction. Secondly, a better understanding of students' reflective processes will assist tutors to facilitate students' development of intercultural competence. Ultimately, this means assisting students to recognise their own situated perspective, as well as how to shift their frame of reference to recognise the perspectives of patients and families, which is crucial for patient-centred, interculturally competent care. Thirdly, the study investigates the value of the online environment as a productive way to facilitate medical students' intercultural learning through peer discussion.





# Chapter Three

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## Theory



## Introduction

In this chapter, I explain the theories that informed my methodology and analysis of students' online reflection. I begin by describing my social constructivist view of learning and how this view influenced my use of online discussions to engage students in reflection about culture in medicine. I then explain the constructivist perspectives of intercultural learning and reflection that I draw on this study. The first theoretical perspective is a constructivist notion of 'subjective culture' or worldview that underpins the definition of intercultural learning in this study. Intercultural learning is integral to the development of intercultural sensitivity—the ability to perceive and analyse cultural differences and identify appropriate strategies for effective interaction. I also discuss worldview in relation to ethnocentrism and the importance of cultural self-awareness for the development of intercultural sensitivity and competence. The second theoretical perspective presented involves Mezirow's (1991) theory of transformational learning, which emphasises the important role of reflection and dialogue to interrogate our 'meaning perspectives'—the structure of assumptions that influence how we construe experience. Next, I provide a detailed description of the Intercultural Development Continuum that I used to examine medical students' intercultural sensitivity online, including my reasons for choosing this continuum. Finally, I introduce Hofstede's dimensions of culture, the theoretical framework of culture that was given to students in the Culture and Health unit to help them analyse the intercultural clinical cases discussed online.

## A social constructivist view of learning

The project involved engaging medical students in online discussions about culture and healthcare. My methodological approach, explained in more detail in Chapter Four, was

underpinned by my social constructivist view of learning. A social constructivist approach holds that learning occurs when students actively construct meaning through interaction with peers (Vygotsky, 1978; Wink & Putney, 2002). Social interaction among peers prompts the learner to find their own voice and listen to others as they engage in collaborative tasks (Sthapornnanon, Sakulbumrungsil, Theeraroungchaisri, & Watcharadamrongkun, 2009). Language, in the form of written posts, is a tool that students use to mediate the development of their thoughts and co-construction of knowledge (Wertsch, 1991; Swan, 2005). Having to explain one's thinking to someone else deepens cognitive processes (Scardamalia & Bereiter, 1994). Students are able to search for understanding, negotiate meaning and construct new knowledge through communication, collaboration and interaction with peers and/or their teacher in the online environment (Swan, 2005).

Vygotsky's (1978) 'Zone of Proximal Development' (ZPD) is relevant to the idea that students can push each other to recognise new perspectives through online discussion about intercultural interactions in medicine. Vygotsky (1978) described the difference between what students are able to understand or achieve working on their own, and what they are able to accomplish with the help of more experienced peers and/or tutors, as the Zone of Proximal Development. In this study, the online discussions invited students to draw on their unique experiences. Students in the sample came from a variety of backgrounds; some students were members of non-dominant groups, others had experience living overseas. Students had the opportunity to bring their lived experience to their reflection and online discussion of the values, motivations and actions of the individuals depicted in the intercultural clinical cases. Through students sharing their knowledge, peers were exposed to a rich variety of perspectives in the online discussions.

This sharing could assist students to gain new insights and recognise alternative perspectives that they might not achieve on their own.

New insights that students gain through online discussion with peers can also be understood in terms of sociocultural learning. Sociocultural learning can occur when students bring different ‘funds of knowledge’ or culturally conditioned knowledge to the learning environment (Moll & Greenburg, 1992). The knowledge, values and beliefs that students bring to the online discussion arise out of different life experiences and backgrounds. This means that students will “come to the task, problem or conversation with their own unique ways of making sense of it” (Tudge, 1992, p. 1365). When students discuss their ideas about the intercultural clinical cases with their peers who have different points of view that contradict their own it can create disequilibrium, and that in turn can cause students to re-examine and question their beliefs and explore new ideas (Piaget, 1985). I was interested to examine if sociocultural learning occurred and if students’ ‘funds of knowledge’ fostered new insights among peers about their own and others’ worldviews that could inform their future practice as doctors.

## **Constructivist perspectives of intercultural learning**

Medical students’ intercultural learning in this study is approached from two theoretical perspectives. The first theoretical perspective draws on a constructivist notion of culture and intercultural learning, which is integral to ‘intercultural sensitivity’—the ability to perceive cultural differences, analyse their impact, and identify ways to interact effectively (Bennett, 2009). The second theoretical perspective draws on Mezirow's (1991) transformational learning, which emphasises the role of reflection in recognising our own ‘meaning perspectives’—the complex structure of assumptions we use to make sense of our experience. Mezirow (1991) argues that reflection can help us to recognise our

meaning perspectives and how they may constrain our perception of an experience. Both intercultural sensitivity and transformational learning are constructivist in that they acknowledge that individuals draw upon prior experience and learning to construct their reality or make sense of experiences (Bennett, 1986, 1993, 2009; 2012; Mezirow, 1991). Intercultural interactions can be challenging because individuals from different backgrounds and/or life experiences may interpret their interactions with one another differently, leading to misunderstanding.

### **‘Subjective culture’ and intercultural learning**

For the purpose of the current study, I expand on the definition of culture presented in Chapter One to conceive of culture in two ways: as ‘objective culture’ (Berger & Luckmann, 1967), and as ‘subjective culture’ (Berger & Luckmann, 1967; Triandis, 1994). Objective culture includes social, political and historical institutions, as well as things such as the arts, music, and cuisine that are created and preserved by a group of people who interact with one another (Bennett, 2009). In contrast, ‘subjective culture’ (Berger & Luckmann, 1967; Triandis, 1994) represents an individual’s particular perspective, worldview, or frame of reference, and includes such things as what we notice or how we differentiate things in our environment, how we organise and manage communication, and what we value or consider good or bad (Bennett, 2009). It is the ‘subjective culture perspective’ or worldview/frame of reference that is relevant to intercultural learning and reflection in this study, which I will refer to in this thesis as an individual’s worldview or frame reference.

The purpose of engaging students in reflection and discussion online about intercultural interactions in a medical context was to foster their intercultural learning about their worldview or frame of reference. In this study, intercultural learning is defined as students’

increasing awareness of their own and others' subjective perspective or worldview and developing the ability to interact sensitively and effectively in intercultural situations (Bennett, 2009). The key concept in this definition is the notion of worldview and refers to our unique perspective (Bennett, 2009). For example, a doctor might explore the patient's perspective of their illness. Recognising that worldviews differ, the doctor may ask how the patient perceives their illness; whether they believe they have control over the circumstances around their illness or see it as something that is beyond their control. Recognising and understanding the patient's worldview or frame of reference is crucial to effective and skilful interaction (Bennett, 2009; Perry & Southwell, 2011). Developing intercultural competence involves recognising that our own subjective worldview or frame of reference is one among many different worldviews (Bennett, 1993; 2009; 2012; Deardorff, 2006). To better understand the process of becoming interculturally competent, it is important to understand how worldview and ethnocentrism are related.

## **Worldview and ethnocentrism**

Our worldview guides us in construing or making sense of our experience (Bennett, 2009; Triandis, 1990). For example, our worldview helps us determine what is considered good or bad, such as, what is a good medical consultation approach, who should make decisions about a person's medical treatment, how a body should be treated at death, and many other facets of medicine and life. If an individual has been exposed to only their own culture (i.e. ways of behaving and constructing meaning), it is natural for them to use their own culture as the measure to judge other cultures and this is referred to as ethnocentrism (Bennett, 2013; Triandis, 1994)). According to research on ethnocentrism, people with an ethnocentric worldview tend to think of their own and other cultures in dichotomous ways (Campbell & LeVine, 1968). For example, an individual with an ethnocentric perspective will think of the norms, social roles and behaviours in their culture/group as 'natural' or

‘correct’ and the norms, social roles and behaviours in other cultures as ‘unnatural’ or ‘incorrect’. They tend to think that what is good for their group (culture) is good for everyone, look favourably on cultural practices that are similar to their own, and dislike cultural practices that are dissimilar (Brewer & Campbell, 1976). These attitudes can be an obstacle to understanding and effectively communicating with others (Triandis, 1990).

The challenge of interacting effectively across cultures and/or negotiating with a person of a culture or worldview different to our own, is being able to “put ourselves in their shoes and look at the world the way they see it” (Triandis, 1990, p. 2). This involves understanding how they are different to ourselves (Triandis, 1990). Interacting effectively across cultures also involves being able to suspend judgement and tolerate the ambiguity that comes with unfamiliar behaviour, while we try to understand or view the situation or behaviour from another perspective (Ang & Dyne, 2015; King & Baxter Magolda, 2005; Leung, Ang, & Tan, 2014).

## **Cultural self-awareness**

Cultural self-awareness or recognising our subjective worldview is considered the starting point for intercultural learning and the development of intercultural competence (Ang & Dyne, 2015; Danso, 2016; Deardorff, 2006; Kumagai & Lyson, 2009). Milton Bennett (2009) explains that cultural self-awareness is not the same as the self-awareness that comes with recognising one’s own personality characteristics or personal likes and dislikes. It is also not the same as recognising objective culture such as a society’s religious beliefs or how certain groups oppress others within a particular society. Instead, becoming aware of our own subjective worldview involves a group level analysis. Cultural self-awareness involves recognising how socialisation within a particular group(s) (e.g. ethnic, regional, national, gender, sexual orientation, etc.), has influenced how we make meaning from our



experience. For example, a student from a dominant cultural background in New Zealand might assume that it is always the patient who makes the decision about their healthcare treatment. However, the student might encounter a patient from another background whose worldview conflicts in that s/he believes it is the family, rather than the individual, who makes the decision about treatment. Medical students need to gain insight into their own subjective worldview or frame of reference and recognise how socialisation within particular groups has influenced the way they view the world and interpret their experience. Insight into our own worldview is crucial to being able to recognise and interact effectively with people who hold different worldviews (Bennett, 2009, 2012).

Developing awareness of one's own and others' subjective worldview is necessary for developing intercultural sensitivity and competence (Bennett, 2009). Intercultural sensitivity can be thought of as “the experience of cultural difference” (Perry & Southwell, 2011, p. 454)—that is, how one constructs the experience of difference (Hammer, Bennett, & Wiseman, 2003). From a constructivist perspective, intercultural interactions do not happen to us. Rather they are a result of how we construe the interaction. If we can increase students' ability to perceive and conceptualise what is occurring in an intercultural interaction, they are more likely to construe the event in more complex ways, and develop a more nuanced interpretation of the intercultural interaction (Hammer, 2011; Hammer et al., 2003; Leung et al., 2014). Increased intercultural sensitivity will enhance their ability to understand the patient's perspective. An expanded awareness of their own and other's frame of reference or worldview can then help them to interact more effectively and improve their intercultural competence.

## **'Meaning perspectives' and students' experience of culture**

I now turn to another constructivist concept that helps us understand how medical students experience cultural difference and construe intercultural interactions. According to Mezirow (1991; 2000; 2009), 'meaning perspectives' are the deeply held, internalised set of assumptions that form our frame of reference and that we draw on to interpret or evaluate our experience. Meaning perspectives provide a guide to evaluate "right and wrong, bad and good, beautiful and ugly, true or false, and appropriate and inappropriate" (Mezirow, 1991, p. 44). There are three types of meaning perspectives: 1) epistemological (e.g., the ways we know and make use of knowledge, concrete versus abstract thinking, and external/internal evaluation criteria, etc.), 2) socio-cultural (e.g., social norms and roles, language and cultural codes, etc.), and 3) psychological (e.g., self-concept, locus of control, and tolerance for ambiguity, etc.). Meaning perspectives are acquired through socialisation and formal schooling and they underlie our subjective worldview. This structure of assumptions influences the way medical students perceive themselves and the actions of their patients. They also impact medical students' general assumptions about how doctors and patients should behave, how the world of medicine should work, and their views of illness (Liimatainen, Poskiparta, Karhila, & Sjögren, 2001).

When we experience a culture that is different from our own, our meaning perspectives or our taken-for-granted assumptions are challenged (Mezirow, 1991). Suddenly things we have always assumed to be true such as how to communicate effectively, or how to obtain information, do not meet with the anticipated response. We may intuitively sense things are going awry but may not understand why. Becoming interculturally competent, involves in part, becoming aware of one's own meaning perspectives (i.e. assumptions) (Bennett, 1986, 1993; Deardorff, 2006) and recognising that alternative meaning perspectives exist (Fitzgerald, 2000).

The intercultural clinical cases used in this study provided an opportunity for students to reflect on and discuss online their own and others' meaning perspectives or taken-for-granted-assumptions. Having students interrogate their own assumptions is crucial to developing cultural self-awareness and recognising that patients and their families may view their illness or the doctor/patient interactions in a different way. Reflection plays a crucial role in becoming aware of our meaning perspectives and recognising that alternative interpretations exist.

### **How do we interrogate our 'meaning perspectives'?**

It is through a process of reflection and dialogue that students are able to make revised interpretations of their meaning perspectives (Mezirow, 1991, 2000, 2009). In this section, I first discuss the role of reflection and then explore how discussion with others is important for gaining new insights that help challenge our thinking.

According to Mezirow (1991; 2009), reflection is crucial to interrogate our meaning perspectives. Reflection in this context involves students examining, questioning, and evaluating the content, process, and premises of their beliefs. *Content* reflection involves students' reflection on what they or others believe. *Process* reflection is reflection on the source or origins of one's beliefs. *Premise* reflection occurs when one is able to critically reflect on the validity or premises upon which one's beliefs are based. Premise reflection is essential for 'perspective transformation' and transformative learning to occur.

There is an important distinction between content/process reflection and premise reflection (Mezirow, 1991). Through content and process reflection, an individual can confirm, negate, elaborate, or problematise their meaning perspectives (Mezirow, 1991). An example of content reflection might involve a student reflecting on the fact they do not

know much about Muslims' beliefs about death and their preferred treatment of the body following death (content). The student realises this lack of knowledge is likely due to the fact that they have had little contact or few friendships with Muslims (process). As a result of content and process reflection, the student recognises the limits of their knowledge of Muslims' beliefs about death and the reason for that lack of knowledge.

By contrast, premise reflection or critical reflection requires questioning the validity of one's beliefs or assumptions and is essential for meaning perspectives to be transformed (Mezirow, 1991). For example, a doctor might assume upon seeing a female client wearing a headscarf or hijab that she is oppressed by the men in her society. However, upon getting to know the client better, the physician may realise that the woman is in fact a strong, intelligent individual who believes that wearing a headscarf is her own choice and that it is intimately connected to her personal relationship with God. This realisation may cause the physician to critically reflect on the validity of his/her previous assumptions about Muslim women and decide to reject his/her previous assumptions because they were inaccurate or distorted. This, in turn, could change the way the doctor interacts with Muslim women in the future. In this way, an individual can go through a 'perspective transformation' and experience transformative learning (Mezirow, 1991). When medical students are able to critically reflect on the validity of their assumptions, they may begin to see how their prior experience and socialisation may have limited their perspective, and recognise that alternative perspectives or worldviews exist. Recognising alternative perspectives and rejecting previous inaccurate assumptions can encourage perspective transformation.

According to Mezirow (1991), in order to experience perspective transformation or transformational learning, we must first be aware of the sources or context of our

assumptions (e.g., beliefs, values, feelings, roles, etc.), and critically evaluate them.

Perspective transformation requires that we feel empowered to examine how socialisation within a particular culture has influenced our beliefs and feelings, and evaluate our own perspective and recognise alternative perspectives (Mezirow, 1991; Taylor, 2008).

Developing new perspectives and strategies for taking action in our life and putting these new strategies into action is an essential part of transformational learning. Recent research highlights transformational learning that emphasises context and positionality or awareness of one's position relative to gender, race, sexual orientation, etc. or relationships between individuals and social structures (Taylor, 2008). These conceptions of transformational learning are especially relevant to the current study. Nevertheless, given the short duration of my study, it was unlikely that students would experience all stages of perspective transformation. However, students might have become aware of their own assumptions and begin to evaluate them. My study explored medical students' ability to notice alternative perspectives and reflect on and question the assumptions they held about doctors and the beliefs that guide their interactions with patients.

Some argue that reflection and dialogue is preferred for encouraging recognition of alternative perspectives and transformative learning (Mezirow, 1990; Plack, Dunfee, Rindfleisch, & Driscoll, 2008). Through discussion with others, and exposure to alternative perspectives we can confirm, challenge or contest our values, beliefs, intentions, and feelings, and so on, and correct distortions or errors in our thinking as we encounter the perspectives and arguments of others ( Lie, Shapiro, Cohn, & Najm, 2010; Mezirow, 1990). As noted earlier in this chapter, the online discussions provided an opportunity for medical students to reflect on and discuss the impact of culture in medicine and discover their own and others' worldviews. In part, the study explored whether, and in what ways, the online environment promoted recognition of alternative perspectives and intercultural

learning— an increased awareness of students' own and others' subjective worldviews, through discussion with peers and tutors.

## **Examining students' intercultural sensitivity/competence**

In this study, I wanted to use a framework that would give an indication of students' intercultural sensitivity/competence. My study involved analysing students' online reflections, largely a cognitive process. Consequently, I chose the Intercultural Development Continuum (Bennett & Bennett, 2003; Hammer, Bennett, & Wiseman, 2003) because it focuses on cognitive processes (perceptions and conceptions) of cultural difference (Chen & Starosta, 2000). It also provides sufficient detail of each stage to allow me to understand where students might be developmentally in their intercultural sensitivity/competence.

There were numerous frameworks to choose from. Some frameworks provide descriptions of the characteristics of intercultural competence (Betancourt, 2006; Campinha-Bacote, 2002; Tervalon & Murray-García, 1998) but do not indicate the development of intercultural sensitivity or competence. These were of little use in my study. However, there are other frameworks that describe intercultural competence as a developmental process (Deardorff, 2006; King & Baxter Magolda, 2005). Deardorff (2006) provides a process model of the development of intercultural competence that describes desired internal characteristics involving attitudes, knowledge and skills that lead to desired internal outcomes (informed frame of reference) and desired external outcomes (effective and appropriate communication and behaviour in intercultural situations). I draw on Deardorff's process model in my analysis of characteristics found in students' online posts; however, the Intercultural Development Continuum provided a clearer demarcation of

students' developmental level. Another model I considered was the Developmental Model of Intercultural Maturity, developed by King & Baxter Magolda (2005). This model proposes that intercultural maturity is multi-dimensional and involves: 1) a cognitive dimension (understanding); 2) an interpersonal dimension (i.e., sensitivity to others); and 3) an intrapersonal dimension (a sense of oneself that allows one to listen to and learn from others). This model describes benchmarks in cognitive, intrapersonal and interpersonal development at three different levels of intercultural maturity. However, I was concerned that the students' online posts would not provide sufficient detail to identify intrapersonal and interpersonal characteristics described in the model. For these reasons, the Intercultural Development Continuum seemed best suited for this research.

### **The Intercultural Development Continuum**

The Intercultural Development Continuum (Bennett & Bennett, 2003; Hammer, Bennett, & Wiseman, 2003) is based on the Developmental Model of Intercultural Sensitivity developed by Bennett (1986, 1993) (see Figure 2). Please note that in this study, Bennett refers to Milton Bennett unless otherwise clarified. Milton Bennett (1986, 1993) developed the Developmental Model of Intercultural Sensitivity after observing the experiences of people in intercultural situations over many years. He was curious to know why some people improved their communication with people of other cultures while other people made no improvements at all. He thought if he could explain why some people improved and others did not, he could assist educators to better prepare people for intercultural encounters. Bennett discovered that as people became more interculturally competent, the quality of their experience changed, which he termed a transition "from ethnocentrism to ethnorelativism" (Bennett, 2004, p. 62). According to Bennett (1986, 1993, 2004), the term 'ethnocentrism' refers to a person's worldview in which they experience their own culture as 'central to reality'. What this means is that "the beliefs and behaviours that people

receive through their primary socialisation are unquestioned [and] are experienced as ‘just the way things are’” (Bennett, 2004, p. 62). Ethnorelativism is different from ethnocentrism in that one’s beliefs and behaviours are experienced as just one way among many ways of organising reality. Ethnorelativism is presented as a contrast to ethnocentrism, but not as a philosophical or ethical position (Bennett, 1993; 2012). Instead, the distinction relates to the way difference is viewed. Rather than viewing difference as threatening or wrong, an ethnorelative worldview involves an effort to build new categories for understanding the differences experienced (Bennett, 1993).

The Intercultural Development Continuum evolved from the Developmental Model of Intercultural Sensitivity (Bennett, 1986, 1993) following confirmatory analysis using the Intercultural Development Inventory (Hammer, 2011). The Intercultural Development Continuum is a theoretically grounded model that proposes that as a person develops intercultural sensitivity, s/he is able to experience (or construe) cultural difference in more complex ways (Hammer et al., 2003). As noted earlier in this chapter, someone’s frame of reference or worldview is based on assumptions that they draw upon to understand their experience (Mezirow, 1991). A person who has been socialised in a largely monocultural context has only their own frame of reference or worldview with which to make sense of (or construe) their experience, and “so they are unable to construe (and thus are unable to experience) the difference between their own perception and that of people who are culturally different” to them (Hammer et al., 2003, p. 423). For example, a medical student trained in a medical context that values a patient-centred consultation approach and a less hierarchical relationship between doctor and patient, may consider that asking questions about the patient’s emotional state is appropriate. If the medical student approaches the consultation from an ethnocentric perspective, they may not recognise that a patient who



views the doctor-patient relationship as hierarchical and formal may view questioning about their emotional state as intrusive.

At the heart of the developmental model of intercultural sensitivity is the idea that the ability to construe experience in more multifaceted ways can allow our own worldview or frame of reference to become more complex (Hammer et al., 2003). An underlying assumption of the model is that a greater awareness of our own and others' worldviews will help us to understand people of other cultures or backgrounds and this, in turn, can improve our intercultural interactions (Bennett, 1986, 1993; 2012).

## Stages of intercultural sensitivity

The Intercultural Development Continuum represents an individual's increasing intercultural sensitivity/competence moving from a less nuanced set of perceptions and behaviours (ethnocentric worldview) to a more complex repertoire of perceptions and behaviours (ethnorelative worldview) toward cultural difference (Hammer, 2011).

According to Bennett (1986, 1993), Hammer (2011), and Hammer et al., (2003), the Intercultural Development Continuum (see Figure 1) represents two worldviews: the ethnocentric (monocultural) worldview, and the ethnorelative (intercultural) worldview.

Each worldview involves two stages with a transition stage of 'minimisation' in between (Hammer, 2011).

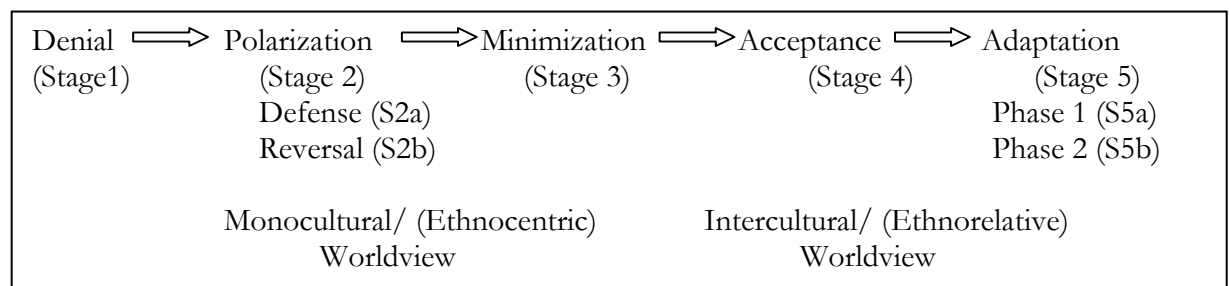


FIGURE 1 INTERCULTURAL DEVELOPMENT CONTINUUM (ADAPTED FROM HAMMER, 2011, P. 475)

The ethnocentric worldview involves two stages: denial (S1), and polarisation (S2).

Someone at the 'denial' stage (S1) may not notice cultural differences or they may not recognise they have a culture. A person at denial stage may notice obvious differences such as cuisine, language or clothing, or they may be indifferent to or disinterested in cultural differences when they are made aware of them. They can also be aggressive in eliminating difference if it impacts on them (Hammer et al., 2003).

A person at 'polarisation', the second stage, is more adept at noticing cultural difference but views their own and other cultures in dichotomous ways and considers their own culture as the only workable one (Bennett, 2009; Harvey, 2017). Polarisation can be expressed as 'defence' or 'reversal'. In 'defence' (S2a), a person can be overly critical of other cultural characteristics and uncritical towards their own cultural characteristics. They may view their own culture as superior and denigrate other cultures as inferior using derogatory terms or stereotypes to describe other cultures (Paige et al., 2003). A person at 'reversal' stage (S2b), views other cultures as better than their own. In 'reversal', a person can be overly critical of his or her own culture and uncritical of other cultures and/or view that culture's traditions as superior. In both 'defence' and 'reversal' the individual's worldview is polarised into 'us' versus 'them'; however, in 'reversal' other cultures are viewed favourably and not as a threat.

Previously, the 'minimisation' stage (S3) was thought to be an ethnocentric worldview; however, recent empirical research has identified 'minimisation' as a transitional stage between the ethnocentric and ethnorelative worldviews (Hammer, 2011). Someone at the minimisation stage tends to minimise cultural differences and thinks of culture as universal or views people as 'all the same'. An individual at the minimisation stage (S3) can identify

and respond to commonalities among cultures but may minimise or fail to appreciate deeper cultural differences (Hammer, 2011).

The ethnorelative (intercultural) worldview involves two stages: ‘acceptance’ (S4) and ‘adaptation’ (S5) (Bennett, 1986, 1993, 2004; Hammer, 2011). Someone at the ‘acceptance’ stage (S4) can appreciate differences and similarities between their own and others’ cultures and recognises cultural differences in the multiple ways that people behave and interact within a particular culture (Hammer, 2011; Hammer et al., 2003). ‘Acceptance’ in this context means that one views his/her own culture as one among many equally complex worldviews and is able to “experience others as different from [ourselves], but equally human” (Bennett and Bennett, 2004; Hammer et al., 2003, p. 425). A person at the ‘acceptance’ stage is able to recognise how cultural differences can influence human interactions in a multitude of ways.

‘Acceptance’ in this model does *not* imply agreement, because some cultural practices may be considered harmful (Bennett, 1986; 1993, 2004; Hammer et al., 2003). However, viewing a particular cultural practice as harmful is not considered ethnocentric, because the individual is recognised as equally human. The challenge when viewing cultural difference from a position of ‘acceptance’ is to recognise that practices may be driven by different values to one’s own, while maintaining commitment to one’s own ethical principles (Hammer, et al. 2003). I acknowledge that some culturally-based practices (e.g., female genital circumcision) raise serious ethical concerns for clinicians. It is important that students discuss and prepare themselves to deal with challenging ethical issues. However, these culturally-based ethical dilemmas are dealt with elsewhere in the medical curriculum and are beyond the scope of this thesis.

‘Adaptation’ is the final stage (S5) in the Intercultural Development Continuum. Someone at the ‘adaptation’ stage is not only able to recognise multiple perspectives but is also able to shift frames of reference and engage in cultural empathy. The first phase of adaptation involves being able to view a situation from another cultural worldview or perspective (S5a). In the second phase of ‘adaptation’, a person is be able to adjust their behaviour or express feelings in culturally appropriate and authentic ways (Bennett & Bennett, 2003; Bennett, 1986, 1993; Hammer, 2011). This requires that an individual is able to hold two cultural perspectives (worldviews) in mind at the same time (King & Baxter Magolda, 2005).

There are two phases of ‘adaptation’. An initial phase of the ‘adaptation’ stage (S5a) entails the ability to shift one’s frame of reference and view a situation from another cultural perspective or worldview (Bennett & Bennett, 2003). This requires ‘cultural empathy’ and involves an “attempt to organise an experience through a set of constructs or ideas that are more characteristic of another culture than one’s own” (Bennett & Bennett, 2003, p.156). In other words, ‘cultural empathy’ involves attempting to have a ‘feel for’, or imagine, an experience or a situation from the perspective of another’s worldview (Bennett & Bennett, 2003; Bennett, 1993). It involves insight into the cultural context of a person’s actions or identity (King & Baxter Magolda, 2005; Shaw, Lee, & Williams, 2015). For example, a physician working with a patient who avoids eye contact and pauses for long periods of time before answering a question may recognise that differences in the patient’s non-verbal and verbal communication patterns can be construed in different ways. So rather than assuming the patient is avoiding contact or communication, the doctor may realise the patient may be showing deference to the doctor or have a different pattern of communication.

A second phase of the ‘adaptation’ stage (S5b) involves altering one’s behaviour based on an awareness of, or feel for, what is appropriate in a particular cultural context (Bennett & Castiglioni, 2004). For example, a physician may sense that a patient is reluctant to share about their emotions or other personal matters, because they do not know the doctor well. Rather than pursuing a line of personal questioning, the doctor may refrain from personal questioning, recognising the need for more time to build up the relationship in order for the patient to feel comfortable sharing personal matters with the doctor. Gaining a feel for what is appropriate in a particular cultural context usually involves gaining first-hand experience with people from different backgrounds. However, students can gain some initial understanding of the underlying values that influence behaviour in different cultural contexts through theoretical frameworks such as Hofstede’s dimensions. (See Table 3, p. 114)

## Hofstede’s Dimensions of Culture

Hofstede’s dimensions of culture (Hofstede, 1980, 2012; Hofstede & Hofstede, 1991) were introduced to medical students in the Culture and Health unit as a theoretical framework for understanding culture. This framework was intended to provide a tool and shared language that students could use to ‘unpack’ cultural differences depicted in the intercultural clinical cases that were the focus of the online discussions in this study.

Hofstede’s (1980) dimensions of culture identify work-related value patterns that were drawn from research in business organisations in 50 countries, in three regions of the world, and at two different points of time. “A dimension of culture is an aspect of culture that can be measured relative to other countries” (Hofstede, 2012, p. 23). These dimensions describe value-based characteristics of countries. From his original research Hofstede (1980) identified four basic dimensions of culture (i.e. power distance,

uncertainty avoidance, individualism versus collectivism, and masculinity versus femininity). A fifth dimension was added later based on a study of students from 23 different countries using a survey designed by Chinese academics (Hofstede & Bond, 1988). More recently in the 2000s a sixth dimension, indulgence versus restraint, was identified with the help of Michael Minkov, a Bulgarian linguist and sociologist (Hofstede, Hofstede, & Minkov, 2010).

The five dimensions used in this study included power distance, individualism/collectivism, uncertainty avoidance, masculinity/femininity, and long-term/short-term orientation. They represent separate but interdependent characteristics that influence both nations and individuals (Dysart-Gale, 2006). A basic familiarity with these five dimensions can help practitioners better understand the perspectives and needs of the patient, and develop sensitive and appropriate plans of care (Dysart-Gale, 2006). The five dimensions, which are described in Table 2, were given to the students in their Culture and Health course book.

TABLE 2 HOFSTEDE'S DIMENSIONS

Power Distance	The extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally. Small power distance cultures emphasise equality within societies and de-emphasise social rank. Large power distance cultures emphasise rank and status in social relations, with different privileges, behaviours and communication based on social status.
Individualism versus collectivism	This dimension focuses on the relationship between the individual and the group (family, society, work, etc.). In collectivist cultures the basic social unit is the group, whereas in individualist cultures the basic social unit is the individual. Individualist cultures value personal autonomy, self-determination and personal responsibility in decision making, etc. Collectivist cultures value interdependence and from a young age. Individuals are integrated into strong, cohesive in-groups, which take responsibility for individuals.
Uncertainty avoidance	The extent to which members of a culture feel threatened by ambiguous or unknown situations. High uncertainty avoidant cultures tend to counter uncertainty with rigid rules and regulations and are intolerant of unorthodox behaviours or ideas. Low uncertainty avoidant cultures tend to not have or like rules and regulations, they are relatively unstructured, and are more tolerant of change.
Masculinity versus Femininity	Masculine cultures are characterised by societies where gender roles are clearly distinct: men are supposed to be assertive, tough, and focused on material success; women are supposed to be modest, tender and concerned with quality of life. High masculine cultures value proactive problem solving and view science as key to addressing many problems. Low masculine cultures are more willing to tolerate problems while solutions are weighed for the possible benefits and disadvantages.
Long-term versus Short-term Orientation	Long-term orientation stands for the fostering of virtues oriented towards future rewards, in particular perseverance, thrift, and adapting to changing circumstances. Its opposite, short-term orientation, stands for the fostering of virtues related to the past and present, in particular respect for tradition, preservation of 'face', and fulfilling social obligations. Patients with long-term orientation may be more willing to persevere with experimental treatments, and be more accepting of changes in clinical approach to their illness. Whereas person with short-term orientation may be more likely to want to rely on traditional remedies, or long established medical practices. They also may be more conscious of their family's desires in terms of treatment plans.

Source: Adapted Hofstede & Hofstede (2005)

It is important to acknowledge that Hofstede (1980) and G. H. Hofstede & Hofstede (1991; 2005) have been criticised for espousing an ‘essentialist’ view of culture that equate culture with national or ethnic background (Goodfellow & Hewling, 2005; Moon, 2008; Signorini, Wiesemes, & Murphy, 2009). Arguably, this theory may lead to stereotyping, the misguided belief that all members of a country have the same characteristics, and a view of national background as determining a person’s values and behaviour without taking other factors into account (Williamson, 2002). Another drawback of Hofstede’s dimensions is that culture may be characterised as fixed and immutable in contrast to something that is dynamic and changing (Reeder, Macfayden, Roche, & Chase, 2004). In this study, I used Hofstede’s dimensions recognising that individuals do not have static, fixed identities, but rather that an individual’s identity often embodies contradictions influenced by particular contexts, histories, gender or socio-economic background, and the like. (Alcoff, 1988).

In this study, I used Hofstede’s (1980) dimensions firstly because they are helpful to illustrate how values can influence behaviour. Secondly, the use of Hofstede’s (1980) theoretical framework provided a starting point and a shared language for students to analyse intercultural interactions. Tutors were encouraged to discuss the dangers of stereotyping and the limitations of this theory with students.

## Conclusion

In this chapter, I have laid the theoretical groundwork for this study to examine medical students’ ability to reflect on their own and other’s worldviews, and how their reflections might inform their future practice. I began by explaining my social constructivist view of learning and how it informed my rationale for involving medical students in online discussions about the impact of culture in medicine. I then introduced the concept of ‘subjective worldview’ or frame of reference, and a constructivist definition of intercultural



learning. I explained the relationship between worldview and ethnocentrism. I also discussed the importance of cultural self-awareness and recognising alternative perspectives as a starting point for developing intercultural competence (Bennett, 2004; Deardorff, 2006; Hammer, 2011). I then introduced Meziow's (1991) concept of 'meaning perspectives' and explored the important role of reflection and discussion to interrogate our meaning perspectives—the structure of assumptions that we draw on to make sense of experience. Following this I described the Intercultural Development Continuum (Bennett & Bennett, 2003; Hammer, Bennett, & Wiseman, 2003), which I used to examine students' intercultural sensitivity in their online posts. Finally, I discussed Hofstede's (1980, 2012) dimensions of culture, a theoretical framework that students were given to inform their analysis of the cultural factors influencing the actions of people depicted in the intercultural clinical cases discussed online.

In the next chapter I explain the methodological approach used in this study, providing an explanation of my rationale for an interpretive, qualitative research approach, as well as a description of the research setting and participants. I also explain the process of ethical approval, and data collection and management, as well as how I conducted my analysis of reflection and intercultural sensitivity observed in students' online posts. I conclude with a discussion of trustworthiness and ethical considerations in relation to this study.



# Chapter Four

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## The Research Process



## Introduction

In this chapter, I describe how I conducted my study. I begin by explaining my methodological approach. I describe the rationale for my interpretive qualitative research approach and how it was underpinned by my social constructivist view of learning and reflection. Following this discussion of methodology, I outline the research process (ethical approval, recruitment, and consent) and describe the participants, my data collection approach, and management of the data. Next, I provide a description of my data analysis process including the development of a reflective framework to identify levels of reflection. I explain how I used thematic analysis to identify students' understandings of the intercultural interactions at different levels of reflection. I then examine what their understandings reveal about their intercultural sensitivity, as determined by the Intercultural Development Continuum. Finally, I discuss trustworthiness and ethical considerations.

## My methodological approach

As mentioned in Chapter One, I took interpretive qualitative approach to this research. An interpretive research approach seeks to understand how people understand or make meaning from their experience (Grant & Giddings, 2002). An interpretive approach also holds that reality is socially constructed, dynamic and open to multiple interpretations (Lather, 2006). This view of social reality is in line with the theories I drew on to analyse my data that were discussed in Chapter Three. They include the belief that the way we interpret or make meaning from an experience is influenced by our prior experience and our subjective and collective meaning perspectives—or our deeply held beliefs, values, and assumptions (Flick, von Kardoff, & Steinke, 2004; Mezirow, 1991; 2009). As explained in Chapter One, growing up in a bi-cultural family, as well as my work in international

education and prior research in higher education has influenced my view that an event or issue is likely to be viewed differently by people and is subject to multiple interpretations. I believe we interpret our experience through a lens that is filtered by our prior experience. Thus, an interpretive research approach was congruent with my constructivist view of social reality and the theories I used to analyse my data.

My role as the researcher within an interpretive approach was to understand the participants' experience by analysing what they said (Grant & Giddings, 2002). This was done by interpreting the importance of what participants said in the online discussion posts and making inferences that the participants may not have been aware of (Grant & Giddings, 2002). There is a tension in the role of the researcher as listener and interpreter of the data. As a participant observer, I attempted to understand the lived experience of the students and at the same time tried to suspend, as much as possible, my own worldview (Maykut & Morehouse, 1994). In an interpretivist research paradigm, the interpreter or inquirer and the participant are thought to influence one another (Lincoln & Guba, 1985). Consequently, it was crucial for me to be explicit about my relationship to the participants and the research being conducted (Grant & Giddings, 2002), which I have attempted to do in Chapter One and later in this chapter in describing the research setting.

An interpretive approach was also in line with my view of learning and reflection as a social process, which I believe occurs as students communicate and engage with one another (Vygotsky, 1978). Both an interpretive approach and a constructivist perspective hold that social interaction is central to how an individual constructs meaning and learns from experience (Flick et al., 2004; Minichiello & Kottler, 2010). Reflection is not only a solitary practice but also a social practice of engaging with others (Wear, Zarconi, Garden, & Jones, 2012). By engaging with others, we allow our ideas to be examined for their

strengths and weaknesses (Dewey, 1944). Through reflection with others we are exposed to different perspectives that can help us to clarify our own thinking (Brookfield, 1995)

This social constructivist view of learning and reflection underpinned the design of this study. Firstly, it influenced my choice of online discussions as a medium to encourage students to reflect on and discuss issues related to cultural differences and the practice of medicine. I aimed to contextualise issues of culture in a clinical context (Hamilton, 2009). I was then interested in examining the ways in which students reflected on and made sense of the intercultural clinical cases in relation to their own others' social and cultural identities (Minichiello & Kottler, 2010). I was also attentive to how interaction with peers online influenced students' intercultural learning. In order to explore these ideas, I analysed students' online written communication, as well as students' and tutors' written feedback.

My aim was to investigate medical students' capacity to reflect about the influence of culture in medicine and what, if any, value online discussion could have for encouraging medical students' reflection. This research was intended to help inform medical educators specifically, and intercultural educators more generally about the relationship between students' reflection and their intercultural sensitivity, as well as ways to encourage reflection about cultural differences in a medical context.

This interpretive approach has both strengths and limitations. The strengths of this approach are the possibility of generating relevant findings to inform teaching practice (Hunt, 2009). The limitations of an interpretive approach are the use of a methodology that is less well accepted in medical education and the use of interpretation in data analysis that meets the demands of rigour and trustworthiness (see discussion of trustworthiness on pp. 126-7) and still adequately investigates the phenomena being studied (Hunt, 2009).

## The research setting

Students who participated in this study were in the first year of their professional medical programme. These students completed a year-long health science course in 2011 prior to being admitted to the medical programme in 2012. Consequently, students who are referred to as ‘second-year’ medical students at this university are actually in the first year of the professional programme. In 2012, second-year medicine was comprised of three year-long courses, alongside the medical sciences. These year-long courses were Integrated Cases, Clinical Skills, and Healthcare in the Community.

The second-year medical curriculum represents a major change for students. The curriculum changes from purely lecture-based, fact acquisition in first-year health science, to team-based, experiential and clinically focused learning in second-year medicine. Through small-group learning sessions, referred to as ‘tutorials’, students are asked to apply biomedical knowledge to clinical contexts via discussion of clinical cases or clinical skills practice (Faculty of Medicine, 2009).

The current study was conducted in the Healthcare in the Community course. This year-long course aimed to develop students’ understanding of patients in a health care context and explored such concepts as “the patient-doctor relationship, the subjective experiences of illness, the patient’s personal context (e.g., family, culture, beliefs, etc.), chronic illness, end of life issues, and becoming a doctor (e.g., developing resilience, practicing safely), etc.” (Faculty of Medicine, 2014, p. 4).

The Healthcare in the Community course was taught via weekly face-to-face tutorials facilitated by experienced, knowledgeable teachers referred to as ‘tutors’. These tutors typically had a clinical background, such as doctor, nurse, or physiotherapist. Most of the tutors in this study had taught in the Healthcare and Community course for several years.



Each tutor had 10 or 11 students in their tutorial. Some tutors taught more than one tutorial.

The online discussions in this study were implemented for the first time in the three-week Culture and Health unit, which was part of the Healthcare in the Community course. The online discussions were hosted on Moodle, the course management system. Prior to commencement of this study, the online course management system was primarily used for posting course materials or sending messages between tutors and students. In fact, half the tutors in the study reported that they had never logged on to Moodle. Consequently, most of the second-year medical students and their tutors had not previously engaged in an online discussion forum on Moodle. Students and tutors both had to become familiar with this technology at the same time that they engaged with the online activities for the Culture and Health unit.

As noted in Chapter One, my involvement with the Culture and Health course began in 2010. Due to my background in intercultural communication, my many years' work in international education, and my study of Mandarin and overseas experience in China, the course coordinator asked me to provide suggestions for improving the Culture and Health unit. On a volunteer basis, I provided suggestions for changes to the curriculum in 2010 and 2011. As a result, I gained an understanding of the structure of the programme, and background on the second-year medical students at this university. In addition, I developed an interest in reflection and reflective practice as it related to medical students' learning and professional practice, through discussions with the course coordinator and lead tutor. In 2010-2011, I was also studying in an online postgraduate course and became interested in the use of the online learning environment to facilitate intercultural learning. My involvement with the Culture and Health unit on a volunteer basis and my postgraduate studies online were the genesis for this study. In 2012, I approached the

Course Coordinator about conducting this study in the Culture and Health unit and he agreed.

## Teaching about culture and health care

In 2012, the Culture and Health unit was considered a starting point for developing students' intercultural competence. The Culture and Health unit included the rationale for learning about culture and healthcare, definitions of terms related to culture, health status, the clinical encounter, and provider focus. The rationale for learning about culture and health was due to: 1) evidence of poorer health outcomes among non-dominant groups in New Zealand; 2) the fact that intercultural consultations are difficult; and 3) that learning to be effective in intercultural consultations is good practice for all consultations. Basic concepts such as definitions of culture, ethnocentricity, and the 'culture of medicine' were also explained. Students explored the clinical encounter through the readings on intercultural clinical cases and a documentary film discussed in weeks one and two tutorials and in the online discussions. The unit addressed the provider's perspective by inviting students to explore their own attitudes and behaviours, or to engage in self-reflection.

A new component of the curriculum introduced in 2012 was Hofstede's (1980) dimensions of culture. As mentioned in Chapter Three, Hofstede's dimensions were intended to provide students with a theoretical framework and a shared language to analyse the intercultural interactions depicted in the intercultural clinical cases and documentary film. The definitions of these dimensions, as described in Chapter Three of this thesis, were given to students in their course guide. The Culture and Health unit also introduced students to the concept of the 'culture of one'. The purpose the 'culture of one' concept was to emphasise that, while Hofstede's dimensions of culture may describe national

groups as a whole, they will be expressed differently by each individual because of their unique history and experiences.

## **Culture and Medicine and the online assignments**

### *Week one tutorial and online assignment*

The week prior to commencement of the Culture and Health unit, students were given the Course Guide and were asked to read the introductory material in that guide and the Orr, Marshall, and Osborn (1995) article about intercultural clinical cases (to be used in the class discussion and the first online activity). The learning objectives for week one included identifying components of 'culture', understanding that each individual belongs to multiple cultures, appreciating the difference between an outsider's and insider's viewpoint of a culture, the negative impact of 'stereotyping', and applying these ideas to intercultural clinical cases in reading material. At the beginning of the first tutorial, students discussed and identified key issues arising in the intercultural consultations in the Orr et al. (1995) article, including what surprised them about the cases, and how the cases were relevant for New Zealand.

The tutors then introduced the Iceberg model of culture. The Iceberg model illustrates how 10% of culture is visible and lies within our conscious awareness, and 90% is invisible or deep internal culture that lies below conscious awareness. Tutors drew parallels to a medical consultation, and the possibility of making assumptions about different groups. The students then engaged in a group activity where, on a diagram of an iceberg, they identified components of the visible and hidden aspects of culture. Next students completed a table in which they identified a culture they felt at home in (e.g. a rugby team, a tramping club, their hall of residence, etc.) and described the visible and hidden dimensions of that culture; they then shared their work with a partner. This activity was

followed by a group discussion of the cultures student had described. Following the discussion, the tutors then presented Hofstede's dimensions (see Table 2, p. 95), and the students discussed the dimensions using examples from their own medical, clinical, or personal culture.

In the final activity, the students identified their experience and understandings of being part of 'student culture', including the values, rules (written and unwritten), and behaviours (phrases, patterns, clothing, etc.). Students discussed whether these characteristics of 'student culture' meant that other people could feel excluded or be 'outsiders' to their shared experiences, and also if it meant they no longer identified with 'other' people or felt excluded from others' groups. The purpose of this discussion was to explore the potential for stereotyping people or groups. The tutorial ended with students working in pairs to apply Hofstede's dimensions to 'student culture' and then sharing examples with the group.

At the end of the week one tutorial, students were given independent work, which included the first online discussion assignment. The week one online assignment required students to succinctly apply Hofstede's dimensions of culture to one of the intercultural clinical cases in the Orr et al. (1995) article. They were asked how Hofstede's dimensions of culture were evident in the behaviours or actions of the doctor, patient, and/or family depicted in the intercultural clinical cases, and how cultural differences may have contributed to the patient outcomes. All students were instructed to post at least two comments: 1) a comment of their own and 2) a thoughtful comment on a classmate's post. In commenting, students were asked to draw on theory, personal experiences, and the readings in this unit. Students were told that the tutor would monitor the discussion and might post a comment to help lead the discussion if it went off track. The students were also asked to limit the length of their posts to 200 words.

### *Week two tutorial and online assignment*

In preparation for the week two tutorial, the students were asked to read introductory material intended to prepare them for the documentary film that they would view in the second tutorial: “Hold Your Breath: A Journey into Cross-cultural Medicine” (Grainger-Monsen, 2007). The introductory material included a brief description of the film, which portrayed an actual case involving an Afghani immigrant to the United States, Mr Kochi, who was diagnosed with gastric cancer. Students were also given medical information on gastric cancer, and a brief history of Afghan immigration to the United States.

The learning objectives for the second tutorial were to understand that patients and healthcare professional often have different perspectives, values, and beliefs about health and illness; and that these can cause difficulties, even conflict, especially when communication is limited by language and cultural barriers. The purpose was to familiarise students with a range of issues and challenges that might arise when caring for patients of different backgrounds. Students were encouraged to think of each patient as an individual, with many different social, cultural, and personal influences, rather than using general stereotypes about particular cultural groups. Finally, it was hoped that students would develop a greater sense of curiosity, empathy, and respect toward patients from cultures different to their own and recognise the importance of improving their communication and negotiation skills throughout their career.

During the week two tutorial, the students viewed the documentary and then engaged in a general discussion about the film. The students were asked to share their impressions of the documentary; what had surprised or disturbed them, and what might have improved the patient’s care. Following this discussion, the students were divided into three groups, and each group was given an issue to discuss. The three issues were: 1) family decision-making and withholding information; 2) effects of immigration and acculturation on family

dynamics and beliefs; and 3) language barriers and communication. Each group was given material on the issue they were assigned, including quotes from the film and questions to prompt discussion. Each group was given 10 minutes for discussion, and then the groups presented to the class their issues and the key concepts from their group discussions.

Following the second tutorial, all students were given independent work, which included the second online discussion. The second online assignment required students to consider the documentary film, “Hold Your Breath: A Journey into Cross-cultural Medicine” (Grainger-Monsen, 2007) and the tutorial discussions, and to share what they had learned about the way in which a doctor’s culture and perceptions may impact on their ability to provide culturally competent medical care. Students were asked to apply what they had learned in the unit about the dimensions of culture, their own personal culture, and the culture of medicine. In addition, students were asked to consider the doctor’s, patient’s, and family’s perspectives in their postings. Similar to the first online assignment, students were instructed to post at least two comments, including a comment of their own, and a thoughtful comment on a classmate’s post drawing on theory, personal experiences and the readings in the unit. The students were also asked to limit the length of their posts to 200 words.

## **Ethical approval and recruitment of participants**

### **Ethical approval**

In 2012, I sought University of Otago ethical approval prior to commencing data collection. The ethics application described the objectives and processes of the study including Participant Information and Participant Consent forms for students and tutors (see Appendix A). I attempted to protect the confidentiality of participants by assigning an alias to each participant for reporting my results. The confidentiality of participants was of

great importance in order for students and tutors to feel free to share their thoughts candidly. In addition, the participants were assured, in writing and also verbally at the time of invitation, that they could withdraw from the study at any time without penalty. Students were informed that the online activity was a compulsory activity for the Culture and Health unit but would not be assessed. The purpose of making the online discussion compulsory was to maximise students' participation and learning. Eliminating the pressure of assessment was intended to help students feel more comfortable sharing their thoughts and feelings (Ma, 2010)

## **Information about online discussions**

Since both students and tutors were unfamiliar with online discussions, I provided all participants with information about how to make a post in Moodle. Also included were guidelines adapted from Plumpton (2005) about how to facilitate online discussions (see Appendix D). The guidelines for students stressed what they could do to make the online discussions more productive. The guidelines for tutors contained key messages to give to students regarding: 1) the length of messages and deadlines for posting, 2) the benefits of online discussion for students' learning, and 3) ways to guide discussion and encourage reflection. The guidelines for tutors were given to them with the Culture and Health unit Tutorial Guide the week prior to commencement of the unit.

## **Recruitment of participants**

### *Tutor recruitment*

In 2012, the year two medical class consisted of 280 students. These students were divided into two groups of 140 students each. Consequently, there were 14 tutorials in group one and 14 tutorials in group two. Each tutorial had 10-11 students. The groups were staggered by one week, with group one commencing a week before group two. Prior to the

commencement of each unit, the lead tutor held a tutor briefing. My invitation to tutors to participate in my study was made at the tutor briefings. However, not all of the tutors attended the tutor briefings, so the lead tutor also invited tutors to participate in my study. Half of the tutors who participated in the study were invited by me in the tutor briefings, and half were invited by the lead tutor at a later time.

During the tutor briefings, I reviewed: 1) the purpose and rationale for the study; 2) the online discussion assignments for both weeks; 3) how to facilitate online discussions; and 4) the reflective rubric on Moodle. An e-learning specialist then showed tutors how to use of the online discussion function in Moodle. Following this introduction to the study and the online discussion function in Moodle, the lead tutor introduced the new material in the Culture and Health unit.

Tutors were invited to participate in the study and informed that participation was optional. Tutors who attended the briefing and who elected to participate in the study were given a Participant Information form (see Appendix A), and Tutor and Student Consent forms (see Appendix B and Appendix C). Tutors were asked to sign the Tutor Consent form and to invite their students to participate during the first tutorial of the unit. Tutors were asked to explain to their class the measures I was taking to ensure participant confidentiality, and to stress to students that participation was optional.

The lead tutor also approached tutors who did not attend the briefings to discuss the aims of the study and ask if they would participate. If the tutor agreed to participate in the study, they were given an envelope containing the Participant Information and Tutor and Student Consent forms. The signed consent forms were returned, in a sealed envelope, to the lead tutor, who, in turn, returned them to me. Only those tutorials where the tutor and all students consented to participate were included in the tutorials to be sampled.



### *Student recruitment*

During the week prior to the Culture and Health unit, students were given the Culture and Health unit guide, a reflective rubric similar to the one on Moodle, and a sheet with guidelines about the benefits of online discussions for their learning and how to maximise their participation online (Appendix D)

Given the large number of tutorials (14 in each of groups one and two), I was unable to personally invite students in each tutorial to participate in the study. Consequently, those tutors who agreed to participate were asked to invite their students to participate. Students were informed of the aims of the study and that: 1) the research was being conducted by a postgraduate student who was not part of the division of Health Sciences; 2) their participation in the research would not impact their grade in any way; 3) their confidentiality would be preserved through assigning aliases to the transcripts of online discussions; 4) the results of the research would not reveal their identity; and 5) their participation was entirely optional. Students who agreed to participate in the study were provided with a Participant Information sheet and asked to sign the Student Consent form provided by the tutor. Students also completed a Participant Demographic Questionnaire (see Appendix E). Students were reminded that they could withdraw from the research at any time without penalty. Later in this chapter, I discuss the ethical issues associated with a third party inviting tutors and students to participate in the study (i.e. the lead tutor inviting tutors to participate and tutors inviting students to participate).

## **Data collection and management**

### **Tutorial discussions**

The data, including online discussions and the feedback questionnaires, were collected between 14 May and 15 June 2012. Only those tutorials where both the tutor and all of the

students in the tutorial agreed to participate were included in the sample. The reason for this was so that both individual posts and entire discussions could be used as a unit of analysis. A purposive sample of 12 tutorials was selected for analysis, six from week one and six from week two (see Table 4).

Table 3 describes the number of students in each tutorial group, the number of posts made by students and tutors in Week 1 and 2, as well as the total number of posts and words each week and the average number of words per post in Week 1 and 2.

**TABLE 3 DESCRIPTION OF TUTORIAL DISCUSSION SAMPLE, NUMBER OF POSTS AND WORD COUNT**

Week One	No. Students	No. posts Std/ Tutor	Week Two	No. Students	No. posts Std/ Tutor
Tutorial-01	10	22/ 0	Tutorial-07	10	20/ 1
Tutorial-02	10	22/ 10	Tutorial-08	10	20/ 0
Tutorial-03	10	18/ 02	Tutorial-09	11	24/ 0
Tutorial-04	10	21/ 05	Tutorial-10	11	09/ 0
Tutorial-05	11	21/ 0	Tutorial-11	10	17/ 0
Tutorial-06	10	15/ 05	Tutorial-12	10	23/ 0
Total students	61		Total students	62	
Total tutors	6		Total tutors	6	
Total posts		119/ 13			113/ 1
Total words		18,913			19,147
Avg wds per post		159			169

I used maximum variation sampling to choose which tutorial discussions to include in the sample (Patton, 2005). For example, with respect to student-student interaction online, I chose some tutorials that contained only short post-reply sequences (i.e., no sequence longer than two-posts) and other tutorials where there was a long discussion (i.e., numerous posts and replies in a sequence). With respect to tutor involvement, I chose tutorials where the tutor was an active participant posting frequently and others where the tutor did not make any posts or only posted one or two comments. The reason for doing this was to address my third research question, to see what factors hindered or encouraged

students' reflection and intercultural learning and determine if there was a difference in reflection based on the tutor involvement online.

### **Students' demographic data:**

The ethnicity and gender of the students in the sample was provided by the Faculty of Medicine business office. In addition, students completed a Participant Demographic Questionnaire (see Appendix E). The Participant Demographic Questionnaire asked for information such as date of birth, country of birth, age, and name. It also asked how long the student had lived in their country of birth, and what countries they had lived in up to the time of the study. The questionnaire asked for their mother and father's countries of birth and current countries of residence. It also asked what languages the student spoke and whether they were an international student at the University. Table 4 includes the ethnicities of the students, their countries of birth, and languages spoken. Table 5 describes the numbers of languages spoken by students. Table 6 includes the age range for 104 students who returned the demographic questionnaire. Not all tutorial groups and/or students returned the questionnaires; therefore, the data on students' ages is incomplete.

**TABLE 4 STUDENTS' ETHNICITIES, COUNTRIES OF BIRTH, AND LANGUAGES SPOKEN**

Ethnicity	Number	Country of Birth	Number	Languages Spoken
NZ European	79	Australia	3	Afrikaans
Māori	11	China	1	Arabic
Chinese	9	Estonia	1	Cantonese
Indian	5	Hong Kong	1	Croatian
British/Irish	4	Hungary	1	Estonian
Korean	3	India	1	German
Other European	3	Korea	2	Hindi
Other SE Asian	2	Malaysia	2	Hungarian
Middle Eastern	2	NZ	76	Korean
Filipino	1	Oman	1	Malay
Samoan	1	Saudi Arabia	1	Mandarin
African	1	Scotland	1	Portuguese
Sri Lankan	1	South Africa	1	Samoan
		Somalia	1	Somali
		Sri Lanka	1	Spanish
		Taiwan	2	Sri Lankan
		England	4	Swahili
		Wales	1	Tamil
		Unknown	25	Te Reo
				Telugu
Total students	123	Total students	123	20 languages

Sources: Faculty of Medicine (2012) and participant demographic questionnaire (2012)

**TABLE 5 NUMBER OF LANGUAGES SPOKEN BY STUDENTS**

Number of Languages Spoken	Number of Students
One language	98
Two languages	22
Three languages	1
Four languages	2

Sources: participant demographic questionnaires (see Appendix E)

**TABLE 6 STUDENTS' AGE RANGE AND GENDER**

Students' Age range	No Students	Gender	
18	2	Female	67
19-21	87	Male	56
22-25	9		
26-37	6		

Sources: participant demographic questionnaires (See Appendix E) and Faculty of Medicine (2012)

## **Student and tutor written feedback**

During the final week of the unit, students and tutors completed a paper-based feedback questionnaire, which asked them to describe: 1) the major benefits of the online discussions for students' learning; 2) the major drawbacks of the online discussions; and 3) their suggestions to improve the online learning experience (see Appendix F). Tutors were asked their views on the efficacy of online discussions to promote medical students' reflective thinking about issues in the Culture and Health unit, and the practicality of facilitating online discussions (see Appendix F). A total of 122 feedback questionnaires were returned by students and 12 by tutors. All 122 feedback questionnaires were analysed for factors that students and tutors felt contributed or hindered reflection and intercultural learning.

## **Managing the Data**

The primary data sources were the online posts in Moodle, the course management system used in the module. With assistance from an IT specialist, an identical copy of all the online discussions in Moodle was created and downloaded to my password-protected computer so I could continue with analysis after the Culture and Health unit concluded, and the 2012 Moodle page was no longer available. This identical copy of Moodle contained all the original online posts for week one and two and gave me access to the original online data throughout the research process.

In order to analyse each online discussion (i.e. two or more posts in a sequence) in the tutorials selected for analysis, I copied these from Moodle and pasted them into a word document, labelled by tutorial number and week (i.e. week-1-tutorial-1). I corrected typographical errors or misspellings in the original posts in the Word document versions to make them easier to read and analyse. I then uploaded the Word documents containing

the discussions to NVivo (version 10), the qualitative software I used for analysing the discussions. I grouped all discussions by tutorial in order to analyse and compare the data by tutorial group and tutor. I also grouped the discussions by week in order to compare differences in students' reflection and intercultural sensitivity, exhibited in the different assignments in weeks one and two.

## **Ensuring confidentiality**

Students' and tutors' names were removed from the Word documents and replaced with aliases. All the participants' names and aliases were recorded in a master spreadsheet ordered by tutorial group, and demographic data was transcribed onto this spreadsheet. The feedback questionnaires did not contain the name of the student or tutor. The questionnaires were transcribed into another spreadsheet. All data were secured on my password-protected computer.

## **Data analysis**

### **Development of the reflective framework**

In order to answer my first research question, what are students' levels of reflection in the online posts and discussions, I developed a reflective framework. After extensive review of different frameworks for evaluating reflection (Bain, Ballantyne, Packer, & Mills, 1999; Ryan & Ryan, 2013; Wald, Borkan, Scott, Anthony, & Reis, 2012; Wallman, Lindblad, Hall, Lundmark, & Ring, 2008), I determined that some frameworks were not suitable in an online context where discussion posts were limited to 200 words. This is because there might not be sufficient detail in the posts to determine levels of reflection (Bain et al., 1999; Ryan & Ryan, 2013). I drew upon the work of a group of reflection researchers who conducted studies within healthcare contexts over more than a decade (Kember et al.,

1999, 2000; Kember, McKay, Sinclair, & Wong, 2008; Leung & Kember, 2003; Wong, Kember, Chung, & Yan, 1995). This research was of particular interest because it drew on the work of Mezirow (1991), whose transformational learning theory was relevant to this study.

These studies of reflection that informed my analysis involved a series of iterations of frameworks to evaluate reflection. The earliest study (Wong et al., 1995) condensed Mezirow's (1991) seven levels of reflection into three broad categories of non-reflection, reflection, and critical reflection. Wong et al. found these categories were effective in evaluating the reflective journals of 45 registered nurses enrolled in a nurse educator course. However, later researchers countered that the three levels did not provide sufficient detail to differentiate between types of reflection (Harland & Wondra, 2011). Kember et al. (1999) used all seven of Mezirow's (1991) levels of reflection to assess the reflective journals of undergraduate students in nursing, occupational therapy, physiotherapy, and radiotherapy, and found that the seven levels were too detailed for coders who did not have an in-depth understanding of reflection.

In 2000, Kember et al. developed a questionnaire drawn from existing literature to evaluate four levels of reflective thinking (i.e. habitual action, understanding, reflection and critical reflection). This questionnaire was tested using confirmatory factor analysis which resulted in a four-factor model. The confirmatory analysis provided "empirical evidence that the most viable scheme for assessing levels of written reflection is likely to have four categories ..." (Kember et al. 2008, p. 372). As a result, Kember et al. (2008) developed a four-category scheme (i.e., non-reflection, understanding, reflection, and critical reflection), which provided clear descriptions for each category of reflection and was recommended as a reliable tool for research and evaluation of students' written reflection in journals, essays, and online discussion forums (Kember et al., 2008). I adapted this four-category scheme

for the current study, but drew on some additional research to inform my definition of critical reflection (e.g., Harland & Wondra, 2011; Hatton & Smith, 1995; Wald et al., 2012; Wallman et al., 2008).

My draft framework was comprised of four levels of reflection: non-reflection, understanding, practical reflection, and critical reflection. I compiled several reflective rubrics into one table that contained: 1) levels of reflection; 2) description(s) of each level; and 3) possible exemplars drawn from the literature (Hatton & Smith, 1995; Kember et al., 2008; Ryan & Ryan, 2013; Wald et al., 2012; Wallman et al., 2008; Wong et al., 1995). This included a brief description of each level of reflection in column one followed by a detailed description in column two and exemplars in column three. Comparable levels of reflection from different authors were listed on the table parallel to one another to facilitate comparison. (see Table 7)

**TABLE 7 EXAMPLE FROM DRAFT REFLECTIVE FRAMEWORK**

Kember et al., 2008 Level of reflection	Kember et al., 2008	Harland & Wondra, 2011
<b>Understanding</b>	<ul style="list-style-type: none"> <li>Evidence of understanding of concept or topic — searches for underlying meaning (evidence of deep approach to learning)</li> <li>Post confined to application of theory</li> </ul>	<ul style="list-style-type: none"> <li>Doctor (and/or patient, family) roles analysed, giving possible reasons for actions taken, but with limited justification</li> <li>connects intercultural effectiveness of medical providers in intercultural clinical cases with theory or course content</li> </ul>

I chose to define critical reflection differently to Kember et al. (2008). Kember et al.’s (2008) description of critical reflection contained only two elements, “evidence of a change in perspective over a fundamental belief of the understanding of a key concept or



phenomenon, and critical reflection is unlikely to occur frequently” (p. 379). It seemed unlikely that the students in the current study would exhibit a ‘major transformation’ in perspective over a fundamental belief given the two-week duration of study. Other authors argued that making a judgement about the “level of significance of the change in perspective is arbitrary” (Bell, Kelton, McDonagh, Mladenovic, & Morrison, 2011, p. 804). Consequently, I developed a definition of critical reflection that combined different conceptions of critical reflection found in the literature. In my study, critical reflection is defined as, ‘critically reviews assumptions, shows evidence of change in perspective and/or a new conception is formed’ (Hatton & Smith, 1995; Kember et al., 1999; Wald et al., 2012; Wallman et al., 2008).

#### *Piloting the reflective framework*

I then piloted the framework with the help of two colleagues, the lead tutor for the Culture and Health unit and an academic who teaches reflective practice in another professional programme. The coders were given an anonymised, purposeful sample of discussion posts (i.e. two or more posts in a sequence) selected from weeks one and two. The sample was chosen to represent maximum variation (e.g., single post-reply sequences, multiple post-replies in a sequence) and variation in tutor posts (e.g., many, some, few tutor posts). The coders were also provided with background information on the unit content, including the reading material students received and a description of Hofstede’s dimensions.

I met with the coders to provide the sample, background information and the reflective framework. I asked coders to code: 1) each student post and 2) each discussion (i.e., two or more posts in a sequence) as a whole for the highest level of reflection exhibited in a sequence. Coders were asked to highlight posts that were difficult to code or good examples of a particular level of reflection. Before coding commenced, I reviewed the reflective framework with the coders, and discussed any questions the coders had about

the definitions, descriptions, or exemplars. The two coders and I then coded the sample independently.

Following the coding process, the coders and researchers met to discuss the similarities and differences in our coding. Discrepancies emerged in how we coded the third level, 'practical reflection,' and together, we discussed possible reasons for this. Based on this discussion, I then refined the framework further, clarifying the criteria used to interpret level three, 'practical reflection'. There were no posts at non-reflection level, so this category was eliminated from the reflective framework. The following are the definitions for each level of reflection (See Appendix G):

**Understanding (L1):** Intercultural clinical case is described in light of course content or theory, but without relating it to personal experience, real-life situations, or practical applications for the students' future practice as doctors. Observations are confined to theory and/or there is reliance on textbook or lecture notes. Students may report what happened or identify an issue and why it is important and/or respond by expressing an opinion, making observation or asking a question(s). However, issues or theory are not applied to future practice or interpreted in terms of themselves or personal experience.

**Practical reflection (L2):** Students apply course concepts or theory to an intercultural clinical case and relate concepts or issues to personal experience and/or future practice. Student may express insights that go beyond book theory, shape a personal philosophy or future practice. This definition of practical reflection contains two key elements of reflection: 1) making sense of the clinical case in relation to self and/or the clinical context, and 2) reimagining or making a connection to future practice (Ryan, 2013). This definition is in line with the literature that indicates reflection can work at different levels and that students must reach a deeper more abstract level in order to rethink or re-imagine their future practice (Kember, 2008; Ryan, 2013).

**Critical reflection (L3):** Critically reviews assumptions, values, and/or beliefs, considers the consequences of actions, demonstrates awareness that actions and events are located in and explained by references to multiple perspectives, and/or shows evidence that they have changed their perspective or formed a new conceptual framework. Critical reflection can also include critically analysing roles and actions within a broader historical, social and/or political context or critiquing assumptions, values, beliefs, and biases.

## Analysing students' levels of reflection

My first research question involved determining what levels of reflection were exhibited in students' online discussion posts. To answer this question, I first immersed myself in the data while students were posting during the week one and week two online discussions. I was given access to Moodle and was able to read students' posts on a daily basis, although I did not comment online. However, I did respond to tutors who posted questions on a tutor forum that was created in Moodle for this project. Tutors' questions related to practical aspects of the project, such as making posts online, and the content of students' discussions. During this early stage of data collection, I was reading the online posts and making notes offline about students' and tutors' online comments. For example, I made a note in a journal about the interaction between the students online, "The students seem to 'talk at' one another rather than engaging in conversation. This may be due to how the tasks were structured".

As explained above, I transcribed or copied posts and replies from each tutorial into Word documents, in order to upload them into NVivo. This provided an opportunity to further immerse myself in the data. This is an important first step in qualitative research; reading and re-reading the data allowed me to become familiar with it, and to begin to identify emerging patterns and themes (Green et al., 2007).

The units of analysis of the data were: 1) an individual post or reply made by a student; and 2) a discussion which consisted of one post and one or more replies. Online posts, like other forms of writing, often contain different levels of reflection or different parts that together make up a whole (Kember et al., 2008). For example, the different parts of a post can include descriptions, application of theory, evaluation, analysis, and synthesis that represent different levels of reflection. Prior research findings on analysing reflection suggest that a piece of writing should be examined as a whole, identifying the highest level

of reflection (Kember et al., 2008). Consequently, to determine the level of reflection, I carefully read each post or reply and consulted my reflective framework to determine the highest level of reflection exhibited. The process of coding the highest level of reflection observed is also in keeping with a common approach for assigning categories in qualitative research (Marton, Dall’Alba, & Beaty, 1993). For example, one can use an inductive or deductive manner to assign categories. In this study, I used a deductive approach using a reflection framework to assign students’ posts to particular category of reflection.

Next, I identified all discussions (i.e. one post and one or more replies) and read through each discussion sequence. I then coded the discussion as a whole based on the highest level of reflection observed in the sequence of posts. The reason for analysing the data in this way was to determine if students’ online discussions produced more reflection than individual posts alone.

In reading through the posts at ‘understanding’ level, I determined that they contained important insights or realisations on the part of students even though they did not meet the criteria for practical reflection (L2). I consulted the literature on reflection and critical thinking and decided to use Critical Thinking Standards (Ash & Clayton, 2009) to help me analyse students’ posts at ‘understanding’ level. (see Table 8) For example, one student at ‘understanding’ level showed breadth in his thinking when he considered the alternative perspective of the Samoan family toward herbal treatments, which may have differed from the doctor’s perspective. He also showed depth when he acknowledged the importance of recognizing the family’s perspective. In this way, the Critical Thinking Standards helped me to describe valuable aspects of students’ thinking at ‘understanding’ level that did not meet the criteria for reflection.

**TABLE 8 CRITICAL THINKING STANDARDS**

Standard	Description
Clarity	Expands on ideas, expresses ideas in another way, provides examples or illustrations where appropriate.
Depth	Explains the reasons behind conclusions and anticipates and answers the questions that the reasoning raises and/or acknowledges the complexity of the issue.
Breadth	Considers alternative points of view or how someone else might have interpreted the situation.
Logic	The line of reasoning makes sense and follows from the facts and/or what has been said.
Significance	The conclusions or goals represent a (the) major issue raised by the reflection.

Source: Adapted from Ash & Clayton (2009)

## **Analysing intercultural sensitivity**

Next, I analysed my data to answer my second research question, what is the relationship between students' levels of reflection and their intercultural sensitivity? Intercultural sensitivity involves the ability to notice cultural differences, analyse their impact, and adapt behaviour for effective interaction (Bennett, 2009).

To determine the relationship between students' intercultural sensitivity and their levels of reflection, I first immersed myself in the data, and using constant comparative method, I looked for themes in students' online posts that related to the impact of cultural differences in the intercultural clinical cases (Boeije, 2002). For example, I coded posts where students discussed the doctor-patient interactions (e.g. doctors need to understand patient's perspective, doctor's culture affects their perception of patient, doctor lacks respect for patient, etc.), through constant comparison, these themes were combined into one category: doctor-patient relationship. This process resulted in categories such as consultations, culture of medicine, doctor-patient relationship, patients, practical applications of cultural dimensions, and socio-cultural information shared by peer.

Next I read through the literature on intercultural sensitivity (Bennett & Bennett, 2003; Bennett, 1986, 1993, 2004, 2009; Hammer, 2011; Hammer, Bennett, & Wiseman, 2003; Paige, Jacobs-Cassuto, Yershova, & DeJaeghere, 2003) and transformative learning (Mezirow, 1991, 1998, 2000; Taylor, 2000) to develop additional characteristics or descriptors that typified each stage in the Intercultural Development Continuum to supplement the basic descriptions described in Table 9 (Hammer, 2011). For example, Bennett (1993) describes a person with an ethnorelative perspective as having a meta-level awareness that involves understanding that subjective worldviews are relative to one another, as well as understanding people's action within the context of their subjective worldview. Another descriptor of the ethnorelative perspective is: 'cultural difference is not viewed as threatening', etc.

I then carefully read through students' individual posts, alternating between the posts and the descriptors of stages of the Intercultural Development Continuum, and additional descriptors of intercultural sensitivity from the literature. I analysed students' posts for the stages of intercultural sensitivity they represented. I then labelled the post with the stage in the Intercultural Development Continuum (see Table 9, p. 128) and noted at what level of reflection the post was coded. I also examined the data for outliers or contradictions within the data. The relationships that emerged between the students' levels of reflection and their intercultural sensitivity were then compared to prior research to see if the findings contradicted or extended the research on reflective ability and the development of intercultural competence.

Next, I was able to identify themes that related to the descriptions of students' intercultural sensitivity at the different levels of reflection. For example, at 'understanding' level (L1), there were examples of a 'defensive' stance in which students were judgemental toward cultural characteristics depicted in the cases. This defensive stance was characteristic of the

‘ethnocentric’ worldview. Other themes were identified that described characteristics of students’ intercultural sensitivity at ‘understanding’, ‘practical reflection’ and ‘critical reflection’ levels of reflection.

**TABLE 9 STAGES OF THE INTERCULTURAL DEVELOPMENT CONTINUUM**

Stage	Description
Denial (S1)	An orientation that likely recognises observable cultural differences (e.g. food) but may not notice deeper cultural differences (e.g. conflict resolution styles) and may avoid or withdraw from cultural differences.
Polarisation (S2)	A judgmental orientation that views cultural differences in terms of “us” and “them”. This can take the form of:
Defence (S2a)	An uncritical view toward one's own cultural values and practices and an overly critical view toward other cultural values and practices.
Reversal (S2b)	An overly critical orientation toward one's own cultural values and practices and an uncritical view toward other cultural values and practices.
Minimisation (S3)	An orientation that notices cultural commonality and universal values and principles that may also ignore deeper recognition and appreciation of cultural differences.
Acceptance (S4)	An orientation that recognises and appreciates patterns of cultural difference and commonality in one's own and other cultures.
Adaptation (S5)	An orientation that is capable of shifting frame of reference or cultural perspective (S5a), and adapt behaviour in culturally appropriate and authentic ways (S5b)

Source: Adapted from Hammer, 2011, p. 475

## **Analysing factors that influenced students’ reflection and intercultural learning**

Finally, I analysed the factors that enhanced or hindered students’ reflection, which was related to my third research question. The sources of data for this analysis included students’ and tutors’ posts, and participants’ written feedback on the usefulness of the online discussions for students’ learning and reflection. I transcribed the students’ written



comments from 122 returned feedback questionnaires. I also transcribed the feedback returned from all 12 tutors. Transcribing the data allowed me to immerse myself in the data immediately following the Culture and Health unit. I made notes on comments that stood out to me as I transcribed this data.

The first way that the factors that enhanced or hindered reflection became apparent was during my initial coding of students' levels of reflection. For example, I became aware of the tutor's role in fostering or hindering students' reflection. In order to consider the tutor's role online, I read through the online discussions in which tutors actively participated with students online. I analysed students' reflections in the posts that followed a tutor's contribution to see if the tutor's comments appeared to facilitate students' reflection or not. For example, one tutor shared how healthcare decisions were made in her family. The tutor's comment prompted a student in that group to reflect on her experience in her own family by describing how her father made the healthcare decisions when her grandmother got ill. Following my observations of the data, I then returned to the literature on facilitating reflection to determine whether my findings corroborated or contradicted by the literature.

Second, I analysed the data in all 122 feedback questionnaires from students and 12 completed by tutors at the end of the Culture and Health unit. I highlighted comments in the excel spreadsheet that contained participants' feedback that revealed both positive and negative issues that were mentioned in the literature, such as students' readiness for reflection, how the time-lapse and written nature of the asynchronous online discussions contributed to students' reflection, as well as how the public nature of online reflection hindered some students' reflection.

Finally, I was interested in ascertaining the effectiveness of certain aspects of the study design, such as the use of intercultural clinical cases in facilitating students' recognition of

the impact of culture in medicine. For example, I analysed students' posts and their feedback questionnaires to see if the cases prompted students to articulate how culture might influence aspects of the doctor-patient relationship or consultations. I then returned to the literature to determine if the students' posts revealed important concepts in the intercultural competence in medicine literature. I also consulted the theoretical models of intercultural competence and intercultural maturity to determine if students were exhibiting characteristics described in these models.

To identify the effectiveness of aspects of the study design, I read through all of the students' and tutors' written feedback to identify both positive and negative comments about the online discussions. I looked for themes that related to the study design, such as the type of questions students were asked, the impact of a word limit, and how online interaction with peers influenced students' learning and reflection. I looked for contradictions in the way the online discussions were viewed by participants in both the written feedback and what I observed in the online discussion data. I did this to form a more complex picture of the effectiveness of the online discussions from the participants' perspectives. For example, while some students found the online discussions interesting and made them reflect more carefully about the topic, other students saw the online tasks as 'busy work' and said that they preferred in-class discussions.

## **Providing for trustworthiness**

I have sought to ensure the trustworthiness of this research, specifically credibility and confirmability, in several ways (Creswell & Miller, 2000; Grant & Giddings, 2002; Lincoln & Guba, 1985). First, to establish credibility, in Chapter One I explained my constructivist view of social reality and my social constructivist perspectives on learning. In Chapters Three and Four, I described the constructivist perspectives I brought to this research and

how these perspectives informed my methodology (Creswell & Miller, 2000; Grant & Giddings, 2002; Lincoln & Guba, 1985). Second, I have described the origins of this study and my position in relation to the participants in the study (see Chapters One and Four). Third, throughout my analysis I have looked for contradictions within the data to identify negative cases that challenge my argument (Creswell & Miller, 2000). For example, in contrast to the positive aspects of the asynchronous online environment for students' reflection, I have also explained the negative aspects of reflecting in a public space online. The challenging aspects of reflecting online appear in the literature and were mentioned by a few students in this study. I have also repeatedly consulted the literature in relation to the data to search for evidence that corroborates or disputes my analysis. I collected data from multiple sources (i.e., students and tutors) in order to corroborate participants' interpretations (Creswell & Miller, 2000).

Finally, throughout this research I have sought opportunities to discuss the research data and my analysis with colleagues. Specifically, I engaged in detailed discussions with my supervisors about the data and my process of analysis. My supervisors often played devil's advocate, raised questions and suggested alternative explanations, which helped to clarify my thinking and sharpen my analysis. For example, one of my supervisors challenged my analysis of students who exhibited 'defence' an ethnocentric perspective (see Chapter Six). He questioned whether these students were being critical thinkers rather than my interpretation of them as being judgemental. In response, I had to return to the literature on ethnocentrism and reframe my argument to make clear why I considered their comments ethnocentric and not critically reflective. I have also participated in research colloquia, workshops, and conference presentations in order to share my research and seek feedback. Underlying the research process has been an attempt to not only scrutinise the data but also scrutinise my actions as the researcher.

In order to establish confirmability, I have attempted to provide enough detail about the process of this research and the thinking behind my analysis to allow the reader to confirm if the findings appear logical from the data I have presented. I make no claim of transferability. My intention in this research is to inform curriculum development and provide sufficient descriptions of the context and process of the research so that others can determine if the findings in this study are applicable to other contexts (Robson, 1993).

## **Ethical considerations**

In this study, I met the requirement for ‘procedural ethics’ through the University of Otago ethical approval process noted earlier in this chapter; there were, however, several ‘ethics in practice’ issues to consider (Guillemin & Gillam, 2004). Firstly, as explained earlier, because of the large number of tutorials in each stream, all occurring at the same time, it was not possible for me to personally invite the student participants. Therefore, I relied on the tutors to invite the students in their tutorials to participate. I anticipated that students might feel obligated to participate in the study when asked by their tutor. I attempted to address this issue by clearly stating in the Participant Information and the Student Consent forms (see Appendix A and B) that participation was entirely voluntary and that students could withdraw from the study at any time.

Secondly, many of the tutors did not attend the tutor briefing and consequently were invited to participate in the study by the lead tutor. It is possible, therefore, that tutors may have felt pressured to participate. To address this issue, the Participant Information and Tutor Consent form stressed that participation was entirely voluntary and that tutors could withdraw from the study at any time.

Thirdly, the students’ autonomy and free expression in the online discussions would have been threatened if they believed their marks (grades) for the course were influenced by

their participation in the study. To address this issue, students were informed that the online discussions would not be marked (graded) and were a compulsory activity for all students taking the course, not just those participating in the study.

Finally, I took several measures to address the issue of participant confidentiality. Students' and tutors' names were removed from the transcription of the online discussion posts, and each participant was given an alias. The actual names of all participants and their aliases were held in a spreadsheet on a password protected computer. In addition, the feedback questionnaires completed by students and tutors were paper-based and contained no names.

## Summary

In this chapter, I began by describing my methodological approach. This included a discussion of my interpretivist approach and how a social constructivist perspective informed my methodology. I then described the research setting, including the origins of the study, the second-year medical programme and the Culture and Health unit, as well as the online assignments. Next, I explained the ethical approval process and participant recruitment processes, as well as data collection and management. This section also included a detailed description of the student participants. Following this, I described my process of analysing students' reflection and intercultural sensitivity, including how I piloted and developed a reflective framework. I also explained how I analysed the factors that enhanced and hindered students' reflection. Finally, I described my efforts to ensure trustworthiness and how I addressed ethical issues in this research. In the next three chapters I present my findings. In Chapter Five I describe the students' levels of reflection in online discussions. In Chapter Six I explore students' intercultural sensitivity at the

different levels of reflection. In the final results chapter, Chapter Seven, I examine the factors that enhanced or hindered reflection.

# Chapter Five

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## Students' Levels of Reflection Online





## Introduction

In this chapter, I provide an analysis of the students' levels of reflection in the online posts and discussions during the Culture and Health unit. The chapter includes a summary of the number of the posts at each level of reflection, observed in weeks one and two. This summary is followed by examples and analyses of the different levels of reflection in the students' online posts and discussions. I also explain a conundrum that emerged when evaluating students' online reflections.

As noted in Chapter Four, the units of analysis were 1) students' individual posts and 2) online discussions (i.e. one post followed by one or more replies). As noted in Chapter Four, I used a three-category framework to evaluate the students' levels of reflection adapted from the literature (Harland & Wondra, 2011; Hatton & Smith, 1995; Kember, McKay, Sinclair, & Wong, 2008; Wallman, Lindblad, Hall, Lundmark, & Ring, 2008).

## Overview: levels of reflection

In this section, I describe the types of reflection observed in students' individual posts during weeks one and two. The majority of posts were at the 'understanding' level (L1), and the next highest number were at 'practical reflection' level (L2). Only one individual post met the criteria of 'critical reflection' (L3) (see Table 10). This is consistent with the existing literature, which indicates that reflection is not intuitive, but rather is a skill that needs to be taught and requires time and practise to develop (Moon, 2013; Ryan, 2013; Wald & Reis, 2010). In addition, critical reflection is rare in undergraduate students' written reflections, especially among those who are new to the practice of reflection (Fook & Gardner, 2012; Kember et al., 2008).

**TABLE 10 FREQUENCY OF POSTS AT EACH LEVEL OF REFLECTION ACROSS THE TWO WEEKS**

Level of reflection	Week one	Week two	Total
Understanding (L1)	35	59	94
Practical reflection (L2)	47	44	91
Critical reflection (L3)	0	1	1

There were a greater number of individual posts during week two compared with week one. A possible reason for this is that the documentary film discussed in week two contained a moral dilemma. The dilemma showed how breakdowns in communication due to culture and/or language differences between the doctor, patient, and/or family can result in adverse outcomes for patients. Stories that contain moral dilemmas are useful for getting students to think about professional norms and expectations (Fitzgerald, 2001).

The moral dilemmas illustrated in the documentary may have generated interest and resulted in more online posts. Another possible reason is that students were more familiar with the online posting process in week two.

## Levels of reflection

Following this brief overview, I now provide a qualitative analysis of the students' online posts and discussions at different levels of reflection. As mentioned earlier, I conducted a qualitative analysis by coding the posts based on my reflective framework.

### Level 1: 'Understanding' in individual posts

The posts at 'understanding' level (L1) indicated students understood the cultural issues in the clinical cases in light of course content or theory. In other words, 'understanding' level (L1) posts showed evidence that students were able to apply dimensions of culture (e.g., collectivism, uncertainty avoidance, power distance, etc.) (see Table 2, p. 95) that had been introduced in the unit in relation to the clinical cases. There were varying levels of

complexity in the L1 posts, with some containing a relatively simple presentation of a concept in relation to the actions of individuals depicted in the case, and others revealing a more nuanced understanding of the concepts. However, ‘understanding’ level posts did not meet the criteria of ‘practical reflection’ (L2) because students did not interpret concepts in relation to themselves or their personal experience, or discuss how their observations or insights might inform their future practice as doctors (Kember et al., 2008).

The following example illustrates how level 1 posts indicated an understanding of a cultural dimension in relation to the case. This example reveals the student’s understanding of ‘power distance’—the extent to which less powerful members of a country or culture expect and accept that power is distributed unequally. Herb (all names are pseudonyms) correctly identified ‘large power distance’ in the actions of a Korean wife who was reluctant to make end-of-life decisions for her husband:

In Korean society ... the interactions ... are predominantly large power distance relationships, where rank and social status are very important in terms of relationships and privileges. The wife was not allowed to make a decision for her husband, as the eldest son had a greater rank than her. The pastor of the church seemed to have a high power, too.... These particular dimensions lead to an inability for the man’s wife to make a decision on his behalf.

Herb viewed the wife’s reluctance to make an end-of-life decision for her husband as an extrinsically driven rule (i.e., “the wife was not being allowed to make a decision”) rather than an intrinsically motivated decision that could have been driven by the wife’s personal beliefs or values. The post contained no reference to the perspective of the care team, and there was little interpretation other than the influence of power distance on the wife’s decision-making ability. The student’s reflection was relatively simplistic in that it presents a one-dimensional view of the case.

In another example of an ‘understanding’ (L1) level post, Matthias indicated he understood the concept of ‘ethnocentrism’ and presented a more nuanced analysis of the care team’s perspective in the Korean family’s case. In the post below, Matthias replied to a classmate who thought the Korean patient’s care team acted in an ‘ethnocentric’ manner. An individual with an ethnocentric worldview does not acknowledge other cultural perspectives, or downplays different perspectives (Bennett & Bennett, 2003; Bennett, 1986, 1993). Matthias disagreed with his classmate’s assessment of the care team as ethnocentric, saying:

I'm not so sure the care team were quite as ethnocentric as you have made out. I think the issue is more that they didn't know what the differences in the [family's] culture were, as opposed to not acknowledging that differences exist, as would be expected with an ethnocentric attitude. The fact that the care team (and the ethics consultant) consulted with a Korean church pastor indicates a genuine attempt to understand the culture and this is not something we would see from an ethnocentric care team. I think this care team acted very well, identifying that cultural differences existed, working hard to understand these differences, and ultimately coming to a resolution that was best for everyone.

Mathias pointed out that the care team’s desire to seek an ethics consultation and consult with the wife’s Korean pastor indicated recognition of cultural differences and a desire to understand those differences. He corrected his classmate and in doing so clarified the meaning of ethnocentrism for other classmates. Mathias then went on to clarify why he thought the care team did a good job—that is, identifying and trying to understand the different viewpoints of the family and the team so a suitable resolution could be found. The student illustrated that he understood the concept of ‘ethnocentrism’ and recognised the importance of the actions taken by the care team to resolve any misunderstandings with the family. The student considered the actions of the care team with respect to the

concept of ethnocentrism. The post was not ‘practical reflection’ (L2) level, because Mathias did not interpret these concepts (e.g., ethnocentrism) in terms of himself or his prior experiences or apply them to his future practice.

Another feature of ‘understanding’ level (L1) posts was the tendency to rely on textbooks or lecture notes for interpretation of concepts, which is characteristic of ‘understanding’ level reflection (Kember et al., 2008). For example, Dan wrote:

... the Gypsy culture could be seen as having ... high uncertainty avoidance. Hofstede states that uncertainty avoidance is “the extent to which people feel threatened by ambiguous situations and have created beliefs and institutions that try and avoid these”. He also stated that uncertainty avoidance is demonstrated by... actions taken ... to maximise the possibility of desired outcomes. In this case, when faced with the uncertainty ... the family of Gypsies tended towards acting in a manner that would adhere to their cultural beliefs ....These actions [are] taken to achieve the desired outcome, [and] demonstrate a culture with a high uncertainty avoidance, with firmly established traditions and beliefs, which are applied to minimise uncertainty.

In the post above, Dan quoted the course booklet and applied the theory to the case in question. Students at ‘understanding’ level are able to apply theory learned from a text but do not explore the practical applications of this knowledge or find ways to apply it to past experience or prior learning. Writing at this level is common among undergraduates who are young and may lack life experience (Kember et al., 2008).

By contrast, other students at ‘understanding’ (L1) level indicated an attempt to recognise the underlying thinking or conceptual frames of the individuals in the clinical case. One student related Hofstede’s (1980) ‘short-term orientation’ (i.e., the desire to hold to long held traditions) to a Samoan family who wanted to use traditional herbal remedies when the patient had not improved following the use of conventional Western medicine. Raquel

said, “The patient’s family seemed to have a short-term orientation... when... they wanted [the patient] discharged so they could treat him with the traditional Samoan remedies.”

Raquel went on to explore what she thought were the underlying cultural frames or worldview (i.e., beliefs and feelings) of the family’s short-term orientation,

They [may have] felt that by allowing [the patient] to be treated with Western medications they were not fulfilling their social obligations and not doing what was in his best interests. Perhaps they felt that the deterioration in his health was some sort of punishment for not abiding by their cultural practices.

Raquel tried to imagine what the family were thinking about (i.e., fulfilling their social obligation) and she empathised with the family by considering how they might be feeling about the patient’s deterioration. This post contrasts with earlier examples of L1 posts in that Raquel considered the underlying frames or worldview of the individuals rather than merely applying a cultural dimension to a particular behaviour or action depicted in the case. Although Raquel provided a more nuanced analysis of the case and indicated empathy for the family’s perspective, her post failed to meet the criteria of ‘practical reflection’ (L2). This was because the student did not interpret the concepts in relation to herself or her personal experience or consider the practical applications for future practice (Harland & Wondra, 2011; Kember et al., 2008; Nguyen, Fernandez, Karsenti, & Charlin, 2014).

## **Level 2: ‘Practical reflection’ in individual posts**

Students’ posts at ‘practical reflection’ level (L2) typically contained comments that illustrated a progression in levels of reflection. L2 posts often began with a general description of the case followed by identification of a cultural dimension(s) (e.g., collectivism/individualism) that was evident in the behaviours of the doctor, patient,

and/or family and indicated the student understood the concept. L2 posts differed from ‘understanding’ level (L1) posts in that students interpreted the concepts in relation to themselves or their personal experience or applied insights to their future practice as physicians (Kember et al., 2008).

The following example from week one illustrates the progression in levels of reflection observed in ‘practical reflection’ level (L2) posts and showed how L2 posts differed from L1 posts by identifying implications for future practice. First, Bret described the case that involved a conflict between a Gypsy family’s beliefs and the treatment plan:

Case 1 describes a 31 year old Gypsy woman who suffers multisystem organ failure and is treated with surgical drains. However, this treatment went against the traditional Gypsy belief that “if a person had unnatural holes in the body at the time of death, the soul could escape and be forced to wander” which [the family] thought was a “fate worse than death.” The patient’s relatives and the tribal chieftain therefore insisted that her surgical drains be removed despite the fact that it would severely deteriorate her health.

Next, Bret compared the family’s perspective on the treatment to the cultural dimension of ‘short-term orientation’, or the desire to hold to long held traditions (Hofstede, 1980):

This behaviour shows the characteristics of a short-term orientated culture, where the [family] members are reluctant to adopt to a new system of care (the surgical drains) but would rather hold on to their traditional values even in the face of direct adverse outcomes (at least medically).

Bret then expressed surprise at how people’s values can differ across cultures and considered the different perspectives held toward the treatment plan:

What surprised me was how different people’s values were across different cultures. Such choice would be deemed unreasonable and heartless in most cultures but in

Gypsy culture, it was the reasonable and kind choice. I'm sure they knew the sacrifice they were making with their choice, but to them, keeping to their tradition and belief was worth the trade-off of their loved one's health. After all, they were doing what they thought was best.

Through his statement, “such would be deemed unreasonable and heartless in most cultures”, Bret expressed how the Gypsy perspective might be viewed by cultures with which he was familiar and compared it to differences in values and priorities held by the Gypsies. Bret then went on to discuss the practical implications of this case by pointing out the importance of the physician not imposing his or her own values on the patient. He made a connection to patient autonomy and seeking compromise with the patient:

Clinicians are not in the position to say "No, this is silly, we're going with my way."  
They shouldn't enforce their own worldview [on] the patients as this violates the patient's autonomy and dignity but instead try to work within the patient's worldview and reach a common ground like what happened in this case.

Bret highlighted the practical implications for doctors of holding worldviews different to those of their patients. Through a process of reflecting on the interplay between the clinician's perspective and the family's perspective, he identified a course of action. The course of action was to negotiate and try to find common ground with the patient.

Bret concluded the post by addressing the students' role as future clinicians and asserted that treatment of the patient goes beyond just treating the disease:

As future clinicians, we need to respect different worldviews because worldviews tend to shape people's emotions and spirituality. Medicine is not limited to treating just the disease itself. It encompasses the whole aspect of health: the physical, the emotional, the social and even the spiritual, and we need to impart importance to each aspect and cater for them equally.



Here, Bret engaged in ‘reconstruction’ (Ryan, 2013); in other words, he imagined another way to approach this intercultural clinical situation. Bret articulated a suggestion as to what best practice might look like for him and his colleagues—respecting and treating the whole person, not just the disease.

This post provides a good example of the progression in levels of reflection observed in ‘practical reflection’ (L2) posts. It began with a description or ‘reporting’ of the central conflict in the case (Ryan, 2013) and identified the cultural dimension of ‘short-term orientation’ as relevant to the case. The student added a personal tenor to the post by acknowledging surprise at how values can differ across cultures, and then comparing the Gypsy family’s values to the values of other cultures with which he was familiar. Bret highlighted the significant issue in the case, acknowledging how different worldviews can affect the patient or family’s view of the treatment. Bret then analysed the implications for himself and his peers in terms of future practice when he stressed the importance of being mindful of the worldview of patients and of treating the whole patient. Bret expressed a view on change (Nguyen et al., 2014) when he articulated a new way of thinking about patient autonomy and approaching intercultural clinical encounters in his future practice. This example illustrates how ‘practical reflection’ level (L2) posts were different from ‘understanding’ level (L1) posts in that students identified practical and/or ethical implications illustrated by the case and articulated how they could apply new understandings to their future practice as doctors.

### **Level 3: ‘Critical reflection’ in individual posts**

There was only one post at ‘critical reflection’ (L3). In this post Raymond focused on the documentary film about Mr. Kochi, an Afghan immigrant to the United States, who was diagnosed with gastric cancer but who chose not to have chemotherapy treatment. The

post was deemed to be ‘critical reflection’ level (L3), because the student’s contribution indicated he was developing a new conception of culture and expressed awareness that the actions of the doctor and patient could be explained by reference to multiple perspectives. The post also explored the challenges associated with a physician’s assumptions in intercultural clinical encounters. Below I provide excerpts from the post and explain how they illustrated different components of reflection, and a progression through different levels of reflection including critical reflection.

Raymond began the post by referring to himself and explained that the central issue for him was assumptions and their relationship to the concept of ‘culture’: “What I’m increasingly becoming convinced of is that culture isn’t so much something you belong to, but instead are the assumptions you make in your day-to-day activities and your way of thinking.” In this statement, Raymond was troubling his prior conceptions of culture. Examining one’s own and other’s underlying conceptual frames is a characteristic of reflective thinking (Nguyen et al., 2014). Questioning conceptual frames is characteristic of critical reflection (Fook, 2010).

The post was exploratory in that Raymond considered a new definition of culture which encompassed both the uniqueness of the individual and commonalities shared with others:

Whilst under this definition each of us does belong to a ‘culture of one’, we can be reasonably confident that we share these assumptions within the broader society in which we live, after all it is from these people we inherited them.

Raymond then identified the central issue or problem that he saw in the case—the problem of assumptions when one encounters a person from a culture different to one’s own:

However when encountering another culture, these assumptions break down.

Sometimes this is extreme and obvious, such as a language barrier and the imperfect nature of translation; sometimes this [is] small and not likely to be encountered except under very specific circumstances, such as Mr. Kochi's objection to the pump based on his religious rituals.

Here, Raymond was attentive to and critical of the potential problem of assumptions in intercultural consultations. He then explained the challenge that doctors face trying to decipher patients' assumptions when time is limited:

It is ridiculous to expect the doctor be able to change their assumptions to match their patient's at the drop of a hat; they simply can't be sufficiently immersed in the culture in [a] short period of time, yet these assumptions remain a barrier to providing fully competent healthcare.

Raymond recognised that a doctor's inability to fully understand the different assumptions held by patients presents challenges in providing quality healthcare. Raymond then 'reconstructed' (Bain, Ballantyne, Mills, & Lester, 2002) what might have happened if the doctor had questioned the patient more:

Had the doctor inquired further into Mr Kochi's supposed absolute refusal of chemotherapy, he may have uncovered that the refusal was merely a limitation (that is, Mr Kochi wouldn't accept a pump [because it would interfere with his ability to pray]).

Raymond pointed out the problematic nature of the doctor's assumptions, saying, "Instead the doctor's own assumption interfered, the assumption that the refusal was a part of Mr Kochi's faith (partially correct but nonetheless damaging) and that one should not enquire further into such matters."

Raymond's post exemplified critical reflection in that he was aware that the actions of the doctor and the events that followed could be explained by reference to the different

perspectives of the doctor and the patient. He also identified some practical implications for future practice and considered the consequences of unquestioned assumptions:

The solution to these problems seems to be both an awareness of our own assumptions and perhaps a reductionist approach. When we know we're engaging with another culture, it seems dangerous to let anything pass unquestioned, especially if we believe it's not in the patient's best interests.

Another characteristic of critical reflection in this post was Raymond's articulation of practice strategies:

It seems that... questioning and discussion on the part of the doctor must be used to ensure that no gaps are left for misunderstanding. It is a daunting task, to ensure your patient's complete comprehension of their condition and your own comprehension of their culture within the short time which an appointment allows. I'm not sure there's any way around this except to perhaps concede to the necessity that greater time and care must be applied, if only because a mistake will mean the time needed to be invested is multiplied tenfold down the road.

Raymond's practical strategies included balancing time constraints with the need to clarify one's understanding of the patient's perspective. Raymond ended his post by focusing on the implications for himself and his peers as future doctors.

To paraphrase Ken Robinson: 'it is difficult to know what you take for granted precisely because you take it for granted.' I guess this is the problem we have to try and overcome ... that our own culture does not impede our ability to provide for others who are different from us.

Raymond drew on an outside source, Ken Robinson, to articulate the problematic nature of being aware of one's own assumptions about another culture's supposed differences. Raymond recognised that a crucial aspect of caring for people who are different from

oneself is to be aware of one's own assumptions, and to try to avoid assuming we understand why people act the way they do.

Raymond's post exemplified critical reflection in several ways. Firstly, the student articulated a new conception of culture as the "assumptions you make in your day-to-day activities and your way of thinking", suggesting that culture included both an individual's 'culture of one', and the shared values one holds with the broader society. Secondly, Raymond's reflection on the assumptions the doctor made about Mr. Kochi's reasons for declining chemotherapy demonstrated the student's awareness that both the doctor and patient were drawing on different perspectives during the clinical encounter. Thirdly, Raymond articulated future practice strategies such as sufficient questioning of the patient to ensure "no gaps are left for misunderstanding" and conceding "the necessity for greater time and care must be applied". Finally, the post ended with a quote revealing Raymond's awareness of the challenges associated with recognising taken-for-granted assumptions. Raymond's analysis, awareness and critique of assumptions is characteristic of critical reflection (Fook, 2010).

### **Example of 'practical reflection' discussion**

Whereas the preceding sections related to individual posts, in this section, I provide an example of a discussion (i.e., one post followed by one or more posts) at 'practical reflection' level (L2). I considered a discussion to be at 'practical reflection' level (L2) if at least one post was at L2. 'Practical reflection' discussions were evident when a student related an issue in an intercultural case to their prior experience or future practice as a doctor. Then peers responded by indicating why the issue was important to them and built upon or expanded on the topic. The example below illustrates how online discussions

allowed students to share an idea and build upon and expand on what others had said, adding different perspectives on an issue that was important to their practice as doctors.

In this ‘practical reflection’ level (L2) discussion, Caleb began his post by focusing on how cultural and linguistic differences between doctor and patient can affect patient outcomes. “The film, *Hold Your Breath*, is a prime example of how language barriers coupled with cultural misunderstandings can lead to unfortunate outcomes for a patient...”. Caleb then related what he had learned from the documentary that he could apply to his future practice as a novice doctor: “This film taught me that I must be aware of my limits as a doctor, and acquire help when it is needed especially in situations where cultural differences exist that may affect my ability to provide adequate medical care.”

Caleb’s post was ‘practical reflection’ level (L2) in that he related the challenges of intercultural consultations to the importance of recognising his limited knowledge in order to provide “adequate medical care”. Being both flexible and humble enough to recognise and acknowledge what one does not know or when one is uncertain in an intercultural clinical consultation is a sign of cultural humility (Tervalon & Murray-García, 1998; Danso, 2016). Cultural humility, which also involves the ability to seek guidance when needed to ensure a good outcome for the patient and learn for one’s future practice, is especially important for novice doctors (Tervalon & Murray-García, 1998). Caleb’s insight triggered his classmate, Celia, to build on his comment about the importance of being aware of one’s limits because, as young doctors, they will frequently face uncertainty:

I think the issue you raised of being aware of our limits is a very significant one. We are going to come across many situations where we have little expertise, and must not be too embarrassed or proud to ask for assistance.

Celia built on Caleb's idea by mentioning that, as novice doctors they will face numerous situations where they may lack expertise or experience. Celia then related the difficulty of admitting ignorance because of patients' expectations of doctors, saying:

It may be difficult to contradict some patients' ideas of the all-knowing doctor, as we do not want them to lose trust in us. However, in order to ensure the best possible patient care it is important we utilise all avenues available to us, including those around culture.

This post is 'practical reflection' level (L2) in that Celia personalised the issue by recognising the limits of their knowledge and its effect on their future practice as doctors (Harland & Wondra, 2011). She highlighted a difficulty of admitting uncertainty to patients because of fear of losing patients' trust. Celia then reframed the issue by stressing how she could provide the best possible care by using all the resources available to her. Celia's comment prompted another student, Gabby, to add yet another perspective on patient trust:

I think you raise a really good point of the patient losing faith in us if we appear weak or like we don't know what we're doing. I think at the same time the patient would probably feel reassured and respected if you were honest with them about your lack of knowledge in a particular area, and shows your desire to protect their best interests by inviting an expert [to help us] make decisions about [the patient's] treatment, or even just taking the time to learn a bit more about their situation yourself so that you are better equipped to help them.

Here, Gabby considered another perspective and reframed the issue by suggesting that being honest with the patient could also engender trust by showing that the doctor is acting in the best interests of their patient. The medical students, in this discussion, seemed to recognise that an important strategy in intercultural consultations is to take time in order to understand the patient's perspective, build trust and be open to learning.

In this ‘practical reflection’ level (L2) discussion, the students explored thoughts and feelings about the challenges of treating patients of other cultures. The discussion was ‘practical reflection’ level (L2) because the students considered the intercultural consultation from the personal perspective of practising doctors. The sequence of posts illustrated how online discussions can promote reflection as students share ideas and build on each other’s comments, expanding the discussion to include multiple perspectives on a topic. The students each contributed different perspectives on the important issue of trust in the doctor-patient relationship, and the complexities of balancing trust and uncertainty in their future practice as novice doctors.

## **A conundrum in evaluating reflection**

While the framework used to evaluate students’ online reflections was effective in delineating what posts met the criteria of ‘practical reflection’ (L2), the data also revealed a conundrum associated with evaluating students’ written reflection. On one hand, some students at ‘understanding’ level (L1) seemed to have valuable insights into the impact of culture in medicine. Their comments showed evidence of a search for understanding and breadth and depth in their thinking even when they did not meet the criteria for ‘practical reflection’ (L2). On the other hand, some L2 posts appeared formulaic and gave the impression that students were saying what they thought the tutor wanted to hear or were putting in a minimum effort on their posts. Evaluating students’ levels of reflection in this study was problematic in that some students were coded lower (L1) because their posts did not meet the criteria for ‘practical reflection’ level (L2) despite having valuable insights. Alternatively, other students met the L2 criteria by mentioning a practical application for future practice, but did so in a superficial manner without providing a rationale for why their insight was important or how their practice suggestions represented best practice. In so doing they seemed to engage in what Ryan (2013) refers to as ‘superficial reflection’. In



the sections that follow, I provide examples of L1 and L2 posts that illustrate this conundrum.

## Valuable insights at ‘understanding’ level posts

It was apparent that even at ‘understanding’ level (L1), students made valuable realisations about the impact of culture on healthcare. These realisations included recognition that patients may view treatment plans differently to the doctor, and that different values and beliefs can affect the treatment plan and trust in the doctor and patient/family relationship. However, despite offering useful insights, these posts did not meet the criteria of ‘practical reflection’ level (L2), because students did not interpret their insights in terms of themselves or their prior experience or relate it to future practice. Below I provide two examples of such ‘understanding’ level (L1) posts.

### *Insight 1: Patients and doctors may hold different perspectives on treatment plans*

In this example, Peter began by referencing his own thinking and then went on to describe ‘uncertainty avoidant’ cultures: “The same case got me thinking about uncertainty avoidance... high uncertainty avoidant cultures will generally prefer established practices over experimental ones.” Here Peter explained the meaning of “uncertainty avoidance” presented in the course materials, a characteristic of ‘understanding’ level (L1).

He then continued by imagining how the Samoan family may have viewed the herbal treatments and why they may have viewed them as an established practice:

The Samoan family in this case probably see their traditional herbal treatments as ‘established’ procedures because their culture has been using them to treat medical issues for centuries, and in their view the Western treatments are probably more "experimental" due to their [lack of] exposure to them.

The post shows breadth in the student's thinking in that he considers an alternative perspective that the family might hold on herbal treatments. Peter then identified the important issue in this case: "I think this case is to about seeing their perspective on the different treatments".

Peter's post did not meet the criteria of 'practical reflection' level (L2) in that it did not interpret the case in relation to himself or discuss the practical application of his insight; it demonstrated his understanding that patients may hold different perspectives to doctors and acknowledged his understanding of the importance of recognising the patient's perspective. Recognition that a patient may hold different perspectives to the doctor is an important first step in navigating doctor-patient relationships and developing intercultural competence (Fitzgerald, 2000; Gray, 2016). Consequently, Peter had a valuable insight that is crucial to the development of intercultural competence in medicine.

*Insight 2: Patient's beliefs influence treatment plans and trust in the doctor-patient relationship*

In another example of an 'understanding' level (L1) post that expressed meaningful insights, Brittany recognised that the cultural norms and beliefs of a family underpinned their desire to remove the surgical drains immediately following death. Again, recognising that cultural norms and beliefs may influence a family's preference of care for a patient is a crucial first step in providing culturally responsive care. Brittany said:

... the decision to remove the surgical drains immediately after the patient's death ...  
was based on the cultural norms and beliefs that having unnatural holes in the body at  
the time of death would cause the soul to escape and be trapped in the living world.  
This cultural norm was the defining influence on the continued treatment of the  
patient.

Brittany's post prompted her classmate, Radha, to make the connection between responsiveness to patient's beliefs and building trust in the doctor-patient relationship: "It was important that the doctors were sensitive [to] the family's beliefs and were able to reach a compromise which led to less anxiety for the family and maintenance of trust between the family and doctors".

These examples illustrate that some students at 'understanding' level (L1) recognised the importance of understanding the patient or family's perspectives and beliefs. In the first example, Peter recognised that the patient's perspective on possible treatment plans, herbal treatments, or antibiotics, may have been different from what the doctor expected and that the important issue in the case was for doctors to 'see' the patient's perspective. In the second example, Brittany recognised that the beliefs and norms of the family determined how the hospital staff treated the body immediately following death. In the final example, Radha explained how a doctor's understanding of and responsiveness to a family's beliefs are important for maintaining trust between doctor and family and reducing anxiety. These examples illustrated how some students had meaningful realisations about culturally responsive care of patients and families in their 'understanding' level (L1) posts. These students demonstrated a desire to understand the different perspectives of patient and family and move beyond standard applications of the theory to course material.

### **'Practical reflection' (L2) posts that appeared superficial**

At the same time that 'understanding' level (L1) posts showed students' desire to understand concepts that are important to practising medicine in an intercultural context, other posts that met the criteria of 'practical reflection' level (L2) appeared formulaic or superficial. 'Practical reflection' posts (L2) that appeared formulaic identified a cultural concept, applied it to the actions of doctor or patient or family in the case, and included

references to implications for future practice, hence they met the criteria for L2. However, these posts lacked a sense that the student had interpreted the new concepts in terms of themselves and instead contained general references to practice. For example, in the quote below, Victor completed the required task by analysing the Korean case in which the wife was reluctant to make end-of-life decisions about her husband's care. Victor ended the post by referring to Hofstede's (1980) dimensions in terms of future practice:

In the Korean culture it is the duty of the eldest son to make decisions about treatment of his father. This is why the wife was unwilling to consent to the withdrawing of his life support. Korea "appears" to be, in this case, a masculine society where gender roles are quite distinct. Men are assertive and make the decisions whilst women are more passive.

The care team (and the ethics consultant) believed that the wife's unwillingness to consent was due to the translation barrier and her inability to understand their request. In fact it was due to a different cultural attitude (dimension) about the relative roles of genders in decision making...

This case demonstrates the practical utility of Hofstede's dimensions and how they will be important to think about when we carry out medical consultations across cultural groups.

The student can be seen as correct in relating the actions of the wife and doctors to Masculine/Feminine cultures referring to theory introduced in the unit. He considered the perspectives of both family and doctors, and then made a general statement about the usefulness of these dimensions for future practice. The post was coded L2 because Victor made reference to future practice. His use of the pronoun 'we' is very generalised and does not indicate real linking of the case to his future practice as a doctor. In addition, he failed to explain why understanding the dimension was important and how understanding these concepts might have a positive impact on his practice or the doctor-patient relationship.

The challenge with reflective tasks is that rather than engage in reflection, students will say what they think the tutor wants to hear. A tutor expressed this idea well when she said:

I do worry ... that they will write what they think we want to read, you know, rather than what they feel. I think ultimately, [the students'] focus is [on] passing ... whatever you set them, first and foremost because, you know, their goal is to qualify...

This tutor's comment illustrated the potential challenge of asking students to reflect in the learning context rather than on an experience. Students may have different intentions toward the reflective task (Boud & Walker, 1998). Some students may have the desire to understand and explore the concepts, while others approach the assignment in a perfunctory manner as a task to be completed with minimal effort.

Prior research indicates that students can vary in their ability to reflect, and prior knowledge and experience can be a factor that influences students' tendency to reflect (Boenink et al., 2004). In this study, students who were intercultural novices or who lacked prior experience with cultures different to their own may have found it challenging to relate the cultural concepts, or the dilemmas illustrated in the intercultural clinical cases, to their prior experience. The lack of prior experience with cultures different to their own could have limited students' reflection (see Chapter Seven for more about students' approaches to the online tasks).

## Summary

In this chapter, I have presented the levels of reflection observed in students' online posts and discussions. The majority of students' posts were at 'understanding' level (L1) and indicated that students engaged in a search for understanding of the cultural concepts in the clinical cases. Students noticed cultural differences in the actions of the doctor, patients, and/or family and tried to understand those actions in light of relevant cultural

concepts. ‘Understanding’ level (L1) posts varied in their complexity. A few L1 posts appeared simplistic in that they identified a particular behaviour and linked it to a cultural dimension or relied heavily on the text to analyse the case. Other ‘understanding’ level (L1) posts indicated students’ attempts to comprehend the patient’s perspective and consider the conceptual frames or beliefs that underpinned the patient or family’s actions.

The next most common level of reflection in the online posts was ‘practical reflection’ level (L2). At L2, students were purposeful in identifying cultural factors in the actions of the individuals in intercultural clinical cases and they articulated the practical applications of their insights to their future practice. These practical applications had to do with recognising that patients may view treatment plans differently to doctors and that it is important to understand the patient’s perspective. This is a critically important concept and an important first step in developing cultural competence (Fitzgerald, 2000; Wear, Kumagai, Varley, & Zarconi, 2012). Students at ‘practical reflection’ level (L2) also recognised the limits of their knowledge in intercultural consultations and the importance of seeking help, as well as a willingness to learn from the patient, all characteristics of cultural humility (Danso, 2016). They also highlighted trust as important in the doctor-patient relationship and noted the challenges of balancing trust and uncertainty in intercultural consultations. Developing cultural humility or recognising the limits of one’s knowledge in intercultural consultations, as well as acknowledging the importance of responsiveness to patient and family perspectives are crucial for developing intercultural competence (Danso, 2016; Lie, Shapiro, Cohn, & Najm, 2010; Tervalon, 2003).

There was one post at ‘critical reflection’ level (L3). In this post, the student appeared to be forming a new conception of culture. Rather than viewing culture as solely about membership in a group, the student was beginning to see ‘culture’ as a way of thinking or construing experience. In addition, this student demonstrated awareness that the doctor

and patient were drawing on different perspectives to interpret their interactions. He also recognised the danger of assumptions in intercultural consultations and provided suggestions for future practice to address this danger. These suggestions included taking sufficient time to communicate and question the patient to ensure understanding. The student's post met the criteria for 'critical reflection' in that he appeared to be forming a new conception of culture, critiqued assumptions, and provided suggestions for future practice (Fook, 2010; Kember et al., 2008).

The fact that the majority of posts were either at 'understanding' level (L1) or 'practical reflection' (L2) level and only one post was at 'critical reflection' level (L3) was not surprising given that many students were likely new to reflection in a medical context. This finding also supports prior research that indicates reflection is a complex skill that students need time and practise to develop (Aronson, 2011; Mann et al., 2009; Moon, 2013). Not only is it important to engage students in reflective tasks early in their medical education (Aronson, 2012), but more feedback from tutors may be needed to facilitate deeper, more critical reflection (Jones & Ryan, 2014).

A conundrum became apparent while assessing students' levels of reflection. On one hand students at 'understanding' level (L1) had valuable insights about the impact of culture in medicine despite not reaching 'practical reflection' (L2) level. On the other hand, some students whose posts were at 'practical reflection' level (L2), appeared to provide perfunctory references to future practice and may have been engaging in what Ryan (2013) refers to as 'superficial reflection'. This finding raised several issues. One issue has to do with the problematic nature of using discrete levels to evaluate reflection. Some students may be clever at meeting the criteria for reflection without genuinely engaging in a search for understanding. Other students may be evaluated at a lower level of reflection but appear earnest about reaching a personal understanding of the material.

The second issue has to do with the reflective framework used to evaluate students' levels of reflection in this study. It appears the framework may not have been fine grained enough to discriminate between genuine 'practical reflection' and 'superficial practical reflection'. The final issue has to do with the pedagogical implications. It may be easier to facilitate students to reflect more deeply if there is an earnest engagement with the topic on the part of the student. Alternatively, it may be more difficult to facilitate deeper reflection in students who approach reflection in a perfunctory manner with minimal effort.

In the next chapter, I explore the relationship between students' levels of reflection and their understanding of intercultural interactions in a medical context. Students' understanding of intercultural clinical cases were influenced by their intercultural sensitivity—the ability to notice cultural differences, analyse how those differences might impact the patient's perspective or worldview, and consider how the doctor might adapt in order to communicate effectively or come to consensus on a treatment plan (Bennett, 1986, 1993). Intercultural sensitivity is a crucial component of intercultural competence because it allows an individual to be responsive to cultural differences that can impede effective intercultural consultations.



# Chapter Six

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**Students' intercultural sensitivity  
at different levels of reflection**



## Introduction

In this chapter, I examine the quality of the students' intercultural sensitivity observed at different levels of reflection (Bennett, 1986, 1993). Intercultural sensitivity in this context involves students' ability to notice cultural differences depicted in the intercultural clinical cases, analyse the impact of those differences, and think through ways to address cultural differences in their future practice as doctors. I also analyse how reflection influenced the students' intercultural sensitivity with the question: "How does reflective thinking help students identify a patient's worldview and their perspective on their illness and/or the treatment plan?" Physicians who can detect and integrate multiple worldviews are better equipped to negotiate a course of action that is acceptable to the patient and/or family (Fuller, 2003; Gregg & Saha, 2006; Twible & Henley, 2001).

I begin by briefly revisiting the role of reflection in recognising our own and others' worldviews. I also review the relationship between worldview and ethnocentrism and the importance of developing cultural self-awareness or recognising how socialisation within particular groups has influenced the way we make sense of experience. I then revisit the process of determining students' intercultural sensitivity and the Intercultural Development Continuum that was used to identify the students' intercultural sensitivity in this study. Following this, I present the themes that emerged and provide examples of the students' intercultural sensitivity observed in their online posts at each level of reflection. I conclude with a summary of key findings.

As noted in Chapter One, the students who participated in this study were early in their medical training. Therefore, the purpose of the Culture and Health unit was to have the students explore the impact of culture in medicine and develop their cultural self-awareness through analysis of their own and others' worldviews depicted in the

intercultural clinical cases. The Culture and Health unit was viewed as a starting point for developing the medical students' intercultural competence.

## **Worldview and ethnocentrism**

A person's worldview influences what they notice, how they communicate, and what they consider to be 'good' or 'bad' (Bennett, 2009). As a result, the experience of cultural difference is not so much a matter of what happens to someone but rather is the result of how they make sense of or construe an experience (Hammer et al., 2003).

An individual who has grown up in a largely monocultural context is likely to use only their own social norms and behaviours as the standard from which to evaluate other cultures, and this worldview is called ethnocentrism (Triandis, 1994). Ethnocentrism can occur as a result of isolation or lack of exposure to other cultures (Paige, Jacobs-Cassuto, Yershova, & DeJaeghere, 2003).

According to Triandis (1990), people with an ethnocentric or monocultural worldview tend to think of the behaviour or practices in their own culture as the 'right' way to behave, and view behaviour and practices of other cultures as 'wrong'. A person with an ethnocentric perspective views their own values, social roles, and norms as 'just the way things are' (Bennett, 2004). They may not notice how their perception of an experience differs from someone from another background, because they draw solely on their own assumptions to understand an experience (Hammer et al., 2003). Someone with an ethnocentric worldview can also be overly critical or even hostile towards the values, social roles, and norms of other groups (Paige et al., 2003).

Getting someone to move beyond an ethnocentric perspective involves developing their cultural self-awareness, or recognition of how socialisation within particular groups (e.g., ethnic, regional, national, and gender, etc.) has influenced the way they view the world and

make sense of their experiences (Bennett, 2009). Students can gain a better understanding of their worldview by being exposed to alternative perspectives or worldviews. When medical students are exposed to different worldviews or perspectives they can recognise that their perspective may differ from that of their patients.

The challenge of communicating with someone from another culture (or negotiating a treatment plan with a person who holds a different worldview) is that we must be able to view a situation from their perspective (Triandis, 1990). This requires that we first decipher how their view of the situation differs from our own (Triandis, 1990), and secondly, that we withhold judgement and tolerate ambiguity while we attempt to understand their perspective or worldview (King & Baxter Magolda, 2005). Reflection is important to this process.

### **Recognising worldviews and developing intercultural competence—the role of reflection**

As mentioned in Chapter Three, the term ‘subjective worldview’ or frame of reference denotes an individual’s particular perspective or cognitive frame of reference for understanding the world and interpreting experience (Berger & Luckmann, 1967; Triandis, 1990, 1994). Our worldview is based on our meaning perspectives—the deeply held, taken-for-granted assumptions about how people should behave and how the world should work (Mezirow, 1991). Meaning perspectives develop through socialisation and through formal education (Mezirow, 1991). Becoming interculturally competent involves, in part, becoming aware of one’s own ‘meaning perspectives’ or how socialisation within particular groups has influenced the way we see the world and interpret our experiences (Bennett, 2004).

Reflection is related to the metacognitive skills, attitudinal skills, and emotional competencies employed in intercultural competence. Metacognitive skills include being able to move beyond our perspective in order to put ourselves in someone else's shoes (Stier, 2006) and view a situation from another perspective (Blasco, 2012). Reflection is crucial to attitudinal skills such as the ability to tolerate the ambiguity that can characterise intercultural encounters and allow a person to suspend judgement in order to see another perspective (Bennett, 2004; Deardorff, 2006; Blasco, 2012). Finally, reflection is related to emotional competencies in terms of understanding our own feelings—where they come from and how they influence our actions, as well as, the frustration, uncertainty and anger that can arise in intercultural situations (Stier, 2006; Byram, 1997; Gudykunst & Kim, 2003).

Reflection appears to play an important role in intercultural interactions and the development of intercultural competence, but to my knowledge, no other studies have specifically analysed intercultural sensitivity in conjunction with a reflection in a medical context.

## **Evaluating students' intercultural sensitivity at different levels of reflection**

This study brings together two frameworks to analyse students' online posts. In Chapter Five, I used a reflective framework to evaluate students' levels of reflection. In Chapter Six, I used the Intercultural Development Continuum (see Table 9 on p. 128) (Hammer, 2011) and characteristics of intercultural sensitivity described in the literature to determine students' intercultural sensitivity observed at each level of reflection (Bennett, 1986, 1993, 2004, 2009; Bennett & Bennett, 2004; Hammer, 2011; Hammer, Bennett, & Wiseman, 2003; Michael Paige, Jacobs-Cassuto, Yershova, & DeJaeghere, 2003). The literature is

woven into the reporting of findings. I then identify themes from the characteristics of intercultural sensitivity evident at each level of reflection. The relationships that emerged between the students' intercultural sensitivity and their levels of reflection were compared to prior research to see if they contradicted or extended the research on reflective ability and the development of intercultural competence.

## **The Intercultural Development Continuum revisited**

In Chapter Two and Chapter Three I described the Intercultural Development Continuum (IDC) used to evaluate students' intercultural sensitivity. The Intercultural Development Continuum is a theoretically grounded framework that describes changes in the way an individual experiences (or construes) difference, which Bennett (1986, 1993, 2012) described as a change from ethnocentrism to ethnorelativism. Ethnocentrism refers to a worldview in which the standards of behaviour, social norms and rules that we acquire through primary socialisation are not questioned and are accepted as the standard for all behaviour (Bennett, 2004). Ethnorelativism is different in that one's own worldview is considered to be one among other equally complex worldviews (Bennett, 2004; Hammer et al., 2003).

The IDC represents two worldviews, the ethnocentric (monocultural) worldview and the ethnorelative (intercultural) worldview with two stages in each worldview, and a transition stage between each (See Table 9, p. 128). As noted in Chapter Three, I chose the Intercultural Development Continuum as an analytical framework because it provided sufficient detail to help me evaluate students' intercultural sensitivity expressed in their online posts. This IDC also gives an indication, in part, of where students are in the development of their intercultural competence (Paige, et al., 2003).

It is important to reiterate what Bennett (1986, 1993) means by ‘acceptance’ in the ‘ethnorelative’ worldview. In this context, ‘acceptance’ refers to the ability to notice similarities and differences in our own and another’s worldview, and identify how cultural differences impact an individual’s interactions or behaviour (Hammer, 2011; Hammer et al., 2003). ‘Acceptance’ in this model does *not* equate with agreement. We may have a negative view of some cultural practices (e.g. female genital circumcision). However, as noted in Chapter Three, a person at ‘acceptance’ stage is not thought to be ethnocentric, because they are able to view the person as equally human, even though they may disagree with a particular value or practice (Bennett, 1986, 1993; Hammer et al., 2003).

## Students’ intercultural sensitivity at different levels of reflection

### Overview

This section provides an overview of my analysis of participants’ intercultural sensitivity evident at each level of reflection. Following the overview, I provide themes and examples including a detailed analysis of students’ intercultural sensitivity at each level of reflection.

The majority of ‘understanding’ (L1) level posts exhibited ‘acceptance’ (S4), an ethnorelative worldview; however, a few ‘understanding’ level (L1) posts displayed ‘defence’ (S2a), an ethnocentric worldview. Students who displayed a ‘defensive stance’ appeared overly critical of unfamiliar cultural characteristics and were unable to suspend judgement to try to view the situation from another perspective. Instead they simplified differences in a way that valued familiar beliefs and practices, and disparaged unfamiliar beliefs and practise. These students also failed to recognise that the same characteristics that they criticised in another culture, also existed in their own culture.



Posts at ‘understanding’ (L1) level that exhibited ‘acceptance’ indicated that students understood an individual’s actions within the context of their worldview. In other words, students identified how a person’s worldview influenced their actions. This indicated that students at L1 were trying to understand the cultural context for people’s actions. However, as mentioned in Chapter Five, understanding (L1) posts failed to interpret the concepts in terms of self, relate concepts to personal experience, or explore a practical application for their future medical practice.

‘Understanding’ level posts differed in the number of perspectives described. There were slightly more ‘understanding’ (L1) posts that identified one perspective (e.g. that of the patient/family only) than posts which identified two or more perspectives (e.g. the patient/family and the doctor). The ‘understanding’ (L1) posts that identified two or more perspectives occurred in the second online discussion regarding the Afghani man who was diagnosed with stomach cancer. The students were critical of the doctor in this case and strove to identify where the breakdowns occurred between patient, family, and doctor. This may have contributed to students identifying more than one perspective.

All ‘practical reflection’ (L2) posts indicated ‘acceptance’ stage (S4), an ‘ethnorelative’ worldview. ‘Acceptance’ stage (S4) was demonstrated by students recognising that the doctors and patients/families depicted in the clinical cases had different but equally complex worldviews that influenced their actions or beliefs. These students were able to suspend judgement and engage in cultural empathy to view the patient’s or family’s actions as understandable from their cultural worldview or perspective. Some students at L2 were able to draw on personal experience to interpret the cultural context of the individual(s) depicted in the case.

Two posts at ‘practical reflection’ (L2) demonstrated the ability to shift frame of reference, an initial phase of ‘adaptation’ (S5a) (Bennett & Bennett, 2003). Shifting frame of reference

involves suspending judgement, and engaging in ‘cultural empathy’ to try to imagine how an interaction could be construed from a different cultural worldview (Bennett, 1998; Bennett & Bennett, 2003; Bennett & Castiglioni, 2004). ‘Shifting frame of reference’ is viewed as a precursor to being able to adjust behaviour based on an awareness of what is appropriate in a particular cultural context (Bennett & Bennett, 2003).

The one ‘critical reflection’ (L3) post displayed acceptance (S4) in that the student considered the perspectives of doctor and patient as understandable from their respective worldviews. This student also recognised the crucial role that assumptions can play in intercultural consultations. As mentioned in Chapter Five, this L3 post also suggested that the student recognised that the actions of the doctor and patient could be explained by references to multiple perspectives or worldviews, a characteristic of critical reflection (Hatton & Smith, 1995). Table 11 provides a summary of these findings.

**TABLE 11 CHARACTERISTICS OF STUDENTS' INTERCULTURAL SENSITIVITY AT DIFFERENT LEVELS OF REFLECTION**

Level of Reflection	Intercultural sensitivity stage	Characteristics of posts
Understanding (L1)	Defence (S2a) <i>Defensive stance</i>	Overly critical of unfamiliar cultural characteristics and unable to suspend judgement and view behaviour from another cultural worldview/context.
	Acceptance (S4) <i>Actions considered in context of person's worldview</i>	Described/recognised one or more perspectives; suspended judgement to view behaviours from a particular cultural worldview/context
	Identified how worldview (underlying conceptual frames) influenced an individual's actions	
Practical Reflection (L2)	Acceptance (S4) <i>Engages in cultural empathy, and draws on personal experience to interpret cultural context</i>	Described/recognised one or more perspectives; suspended judgement to view behaviours from a particular cultural worldview/context
	Initial phase of Adaptation (S5a) <i>Suspends judgement, engages in cultural empathy to shift frame of reference</i>	Suspended judgement & displayed cultural empathy to shift frame of reference to imagine another cultural worldview/context
	Identified how worldview (underlying conceptual frames) influenced an individual's actions, and interpreted insights in relation to themselves or personal experience or made reference to the practical application of insights to their future practice as doctors	
Critical reflection (L3)	Acceptance (S4) <i>Recognises the importance of assumptions</i>	Described/recognised how events could be explained by reference to multiple perspectives
	Identified the importance of being aware of assumptions in intercultural consultations; suggested strategies to try and ensure accurate communication and understanding of the patient	

## Intercultural sensitivity in 'understanding' level (L1) posts

### *Defensive stance*

Understanding (L1) level posts included examples of both ethnocentric and ethnorelative perspectives. An example of an ethnocentric perspective was evident in a post that displayed a defensive stance or 'defence' stage (S2a). At 'defence' stage (S2a), individuals tend to view unfamiliar cultural characteristics in a negative light and/or view their own culture as superior (Bennett 1986; 1993). An example is John's post, which began by identifying power distance as the cultural dimension at work in the case where the Korean wife did not want to make an end of life decision for her husband:

... within the Korean [culture] that the couple belong to there is[large] power distance.

The women are not allowed to make medical decisions for their husbands. This is viewed as the duty of the eldest son. Thus the person who knows the patient best, the wife, is not making an incredibly important decision on behalf of him.

John viewed the wife's unwillingness to make a decision in negative terms, "the women are *not allowed* to make decisions for their husbands" (my emphasis). John's comment implied that Korean women were powerless to make a decision. He did not appear to consider that the wife might be making a personal choice not to make the end-of-life decision for her husband. John then drew on his own worldview as the superior standard to evaluate the wife's actions, "thus the person who knows the patient best, the wife, is not making an incredibly important decision". From John's perspective, it is the wife who knows the patient best so she should make the end-of-life decision. He made no attempt to view the situation from the wife's perspective or consider the possible reasons why the wife may not have been comfortable with making the decision. John continued by disparaging the way decisions were made in Korean culture,

“For me it basically defies common sense. The best outcome in a rather grave situation for the family would be to have the wife make an immediate decision...I believe high power distance cultures will always have this problem. Rules that make no sense will stay around for a long time .... I think the choice of who makes decisions with high risk consequences should always fall back on ... common sense and not outdated beliefs.

For John, the wife's actions were viewed as negative because they defied 'common sense', and because they did not fit with his superior worldview of how decisions should be made. John displayed an ethnocentric perspective when he denigrated 'power distance' as 'rules that make no sense' and used derogatory terms such as 'outdated beliefs' to describe the Korean worldview. John failed to see that large power distance relationships also existed in his own culture and in medical culture (Lupton, 2012). John characterised decision-making practices from his worldview as 'common sense' or 'correct', whereas he denigrated the wife's decision-making preferences as 'outdated beliefs' or 'wrong'. John showed a lack of open-mindedness to try to view the case from the wife's perspective and assumed his perspective on end-of-life decision-making was the only viable one, which is also characteristic of an ethnocentric perspective (Triandis, 1990).

John's post started an online exchange between students that contained several other examples of 'defensive stance' (S2a). One reply is of particular interest because it represented an interesting mix of 'defence' and an attempt to view the situation from the Korean wife's perspective, a characteristic of 'acceptance' (S4). In this example Cary began her post by agreeing with John:

I completely agree with everything John has said. As a female, it frustrates me to [see] situations where females are obviously unimportant or treated as worthless/unable to make decisions.

Cary assumed that Korean women were negatively viewed as “unimportant or treated as worthless”. Cary’s comment reflected ‘defence’ (S2a), an ethnocentric worldview, in that she characterised Korean culture in negative stereotypical ways and made assumptions that women were ‘unimportant or treated as worthless...’ in Korean culture. Cary’s comment represents an ethnocentric worldview in that she evaluated the actions of the wife as ‘wrong’, because they did not fit with her superior cultural practices. However, toward the end of her post, Cary attempted to view the situation from a Korean perspective,

However, I can believe that from within the [Korean] culture, these rules would be seen as the norm and not as crazy or incorrect. The Korean women are born into a culture where they did not expect to have any power, unlike females in our society.

Cary attempted to view the situation from the wife’s perspective by recognising that people are the product of their culture and thus may not question their cultural practices. In trying to view the situation from the wife’s perspective, Cary showed development toward ‘acceptance’ (S4), in that she acknowledged there was another way to view the situation. Bennett (1993) indicates that individuals can begin to develop sensitivity in each stage of the Continuum at the same time. This means Cary could be developing ‘acceptance’ while still holding an ethnocentric perspective. Cary maintained an ethnocentric perspective in that she assumed Korean women were powerless, without considering that women may have power in other ways or that this case may not represent the views of all Korean people. Also, typical of an ethnocentric worldview, Cary contrasted a negative view of Korean culture (“they did not expect to have any power”) with a positive evaluation of her own culture (“unlike females in our society”). Individuals in ‘defence’ (S2a) tend to be overly critical of other cultures and uncritical toward their own cultural practices; they also experience their own culture as ‘normal’ or the best way to be (Bennett, 2004; Hammer, 2011).

### *Actions considered in the context of a person's worldview*

In contrast to students who demonstrated 'defence' stage (S2a), the majority of students at 'understanding' (L1) level expressed 'acceptance' (S4) in that they suspended judgement and recognised that the patient's or family's views were understandable from a different worldview, a characteristic of an ethnorelative perspective (Bennett, 1986, 1993).

'Acceptance' does not imply agreement. The doctor may disagree with a patient but understand how the patient's viewpoint makes sense from their perspective, and also realise how their own viewpoint is culture bound (Gray, 2014).

An individual at 'acceptance' considers a person's actions within the context of their subjective worldview (Bennett, 1986; 1993). For example, in response to the documentary film, "Hold Your Breath" (Grainger-Monsen, 2007) about the Afghan immigrant in the U.S who developed stomach cancer, Cade discussed the different perspectives of the patient, his daughter, and the doctor. Cade wrote:

I think that there is a large contrast between the two dominant cultures in this film (being Western-English and Eastern-Arabic). Mr Kochi is very passive in his approach to treatment with the doctors wanting to be aggressive. Also Mr Kochi's daughter, who has much more Western characteristics than her father, wants to intervene more. Mr Kochi believes it is up to Allah to decide his time [of death] and that we cannot change it, in contrast Western culture is more inclined [to believe] that we don't have a set time [to die] and to do whatever is possible [to treat the patient].

Cade noticed the patient's different perspective when he said that Mr Kochi was very passive in his approach to his illness and explained the rationale behind this approach: "Mr Kochi believes it is up to Allah to decide his time [of death] ..." Cade was not judgemental toward Mr Kochi's perspective, but rather Mr Kochi's worldview (i.e., his belief that Allah decides his time of death) provided an explanation for his actions.

Another important feature of ‘acceptance’ at ‘understanding’ level (L1) is that different worldviews were not viewed as threatening and were not denigrated. Rather, Cade made an effort to incorporate different viewpoints into his understanding of the case, which is indicative of acceptance (Bennett, 1986, 1993). “Mr Kochi believes it is up to Allah to decide his time [of death]...Western culture is more inclined [to believe] that we don’t have a set time [to die] and to do whatever is possible [to treat the patient]”.

In consultations, it is crucial that doctors recognise that their perspective on a course of action and what is considered ‘right’ or ‘wrong’ is culture bound (Gray, 2014). Resolving differences in ethically complex intercultural consultations requires substantial consultation skills (Gray, 2014). In cases where the patient’s worldview conflicts with the doctor’s treatment plan, it is important that the doctor educate him/herself about the patient’s frame of reference and reasoning behind their decisions (Anand & Lahiri, 2009). This could include researching specific cultural beliefs in combination with respectful discussions with different members of the patient’s cultural group (Anand & Lahiri, 2009). “For the consultation to be effective the doctor needs to ... accept that the patient’s position is valid [from their perspective] and to place the focus not on proving who is right or wrong, but on understanding all the specifics of the case in point, the areas of agreement, the areas of disagreement and then negotiate a way forward” (Gray, 2016, p. 3). It is also crucial that the doctor considers the consequences of their recommendations for the patient or family, and balances their own theory about the illness/treatment plan with the well-being of the patient (Anand & Lahiri, 2009).



## Intercultural sensitivity in 'practical reflection' level (L2) posts

*Suspends judgement, engages in cultural empathy and draws on personal experience to interpret cultural context*

Practical reflection (L2) level posts also demonstrated 'acceptance', typically identifying more than one worldview or cultural perspective. In this section, I present two examples of practical reflection level posts and explain the intercultural sensitivity evident in these posts. The first example of practical reflection (L2) concerns the case of a Mexican patient who had been receiving outpatient treatment for Lymphoma, a form of cancer, for two years. The patient's condition had worsened and he was admitted to hospital. His family told the physician that the patient was not aware of the seriousness of his condition and requested that the doctor not tell the patient that his illness was terminal. The student, Fabiana, began the post by presenting the worldview of the doctor and the family, and explained the values that underpin each perspective:

The physician demonstrates the individualist cultural values of autonomy (informed consent) and personal responsibility. He feels uncomfortable keeping the diagnosis and treatment plans [from] the patient. However, the patient's family members portray collectivism where as a family unit, they feel it's wiser, not breaking the bad news which might 'harm' the patient (e.g., psychologically). In this case, the patient... adheres to the treatment without questioning his family members or the doctor.

Fabiana's post exemplified 'acceptance' (S4) in that she presented the different perspectives of both the doctor and the family/patient without judging the family or patient on the standard of her own culture or worldview. She identified that the doctor valued individualism, providing the examples of 'informed consent' and personal responsibility, and noted the doctor's discomfort with the family's request to withhold the diagnosis from the patient. Fabiana then explained that the family exemplified collectivism in that they believed the group rather than the individual should make the choice about

disclosure of the illness. Fabiana went on to explore the patient's reaction and why it stood out to her:

I find this interesting because if I were the patient, it will be difficult to adhere to the treatment without knowing the cause and effects of the treatment. In my opinion, the patient's unwillingness to further question [the doctor] about his condition may be due to his 'pure' refusal to know-acknowledging the fact that his family knows what's best for him or his worries about his condition, in turn, may burden his family further.

What stood out to Fabiana was the patient's reaction because it conflicted with her own values, "if I were the patient it will be difficult to adhere to the treatment without knowing the cause and effects of the treatment". Fabiana analysed the patient's perspective by comparing it to her own. Although the patient's perspective clearly differed from her own, Fabiana did not denigrate it nor cast it as 'wrong'. Instead, Fabiana interpreted the patient's actions as an acknowledgement of the trust he had in his family to know what was best. Students in 'acceptance' distinguished cultural differences and drew upon a self-reflective perspective to experience others as different from themselves but equally human (Bennett, 2004). The ability to suspend judgement and recognise alternative perspectives is a characteristic of an ethnorelative perspective (Bennett, 1986; 1993).

Fabiana's ability to imagine the patient's viewpoint exemplified cultural empathy (Bennett, 1993). Fabiana demonstrated cultural empathy when she speculated that the patient may have felt that his worry would be an added burden to the family. In essence, Fabiana was able to imagine the different ways in which the patient might construe his experience (Mezirow, 1991). This ability to empathise or imagine another's perspective exemplified shifting frame of reference, which is the first phase of 'adaptation', the fifth stage in the IDC (S5a) (Bennett, 1986, 1993, 1998; Bennett & Bennett, 2003). Fabiana then interpreted

the case in terms of her own experience when she examined her Malaysian culture by comparison:

In my own culture, doctors tend to break news to family members first and expect them to inform the patient or the patient picks up any ‘unusual’ demeanours (‘over concerning’ or ‘over caring’). Then it is [up to] the whole family to decide on the treatment plans. However, this has changed over the years where doctors are taught to be more open and frank [with] the patients themselves.

Fabiana recognised the multiple cultural contexts at work in the case (i.e., the medical culture and the patient/family culture) and related it to her own experience, which is an important skill for interculturally competent consultations (DeSantis, 1994). Fabiana drew upon her personal experience to present an alternative viewpoint by sharing how patients are notified of their illness in Malaysian Chinese culture and explaining how this practice has changed in recent years. This illustrated a level of cultural self-awareness that was characteristic of some students at ‘practical reflection’ (L2) level who were able to draw upon personal experience to analyse a case. Fabiana did this by comparing patient notification in her own culture with notification practices depicted in the case. It is important that medical students are self-aware and reflect on their own cultural identities to check assumptions and preconceptions in order to provide culturally responsive care (Canales & Bowers, 2001; Kumagai & Lyson, 2009; Muñoz, 2007; Wear, 2003). Fabiana suspended judgement and used cultural empathy to recognise the different, but equally complex, worldviews of the doctor, patient, and family, which exemplified ‘acceptance’ (S4) an ethnorelative perspective (Bennett, 1986, 1993).

#### *Engages in cultural empathy and shifts frame of reference*

Another ‘practical reflection’ (L2) level post also illustrated a student engaging in cultural empathy and shifting frames of reference, an initial phase of ‘adaptation’ stage (S5a). In

this example, Hannah tried to understand the differences in how the doctor and patient viewed their relationship, and how misunderstanding or breakdowns in communication can occur. Hannah discussed the case of a Samoan agricultural worker who contracted *Cryptococcus meningitis* suffering sudden blindness and other symptoms. The worker was treated in hospital with intravenous antibiotics, but after six weeks his condition deteriorated and the family requested to take him home so they could treat him with traditional herbal remedies. Hannah began by identifying power distance as a factor in doctor-patient interactions (i.e., the extent to which less powerful members of organisations within a country expect and accept that power is unequally distributed). She said:

I think a possible issue in this [case] is the power distance experienced between the doctor and patient in the building-up of the relationship, prior to the issue of 'western' vs 'traditional' Samoan medicine. Before it became an issue of conflicting beliefs (re: choice of effective medicine), it may have taken root primarily as a difference in understanding in how to communicate in a modern doctor-patient relationship.

Hannah suggested that the doctor-patient relationship may have been undermined early on by differences in power distance and communication patterns. Hannah imagined that these differences were caused by the dissimilar ways in which the doctor and family viewed the doctor-patient relationship. The post continued with Hannah analysing the potential differences in the patient's and the doctor's perspectives on how to interact, indicating she may have had some knowledge of Pacific cultures:

This may well have resulted in the misunderstandings and miscommunications between the two parties. The Samoan man comes from a culture where he must not make eye contact with an elder/more educated person, and may consider himself to have very little freedom in the decision making process. The doctors, probably from a western culture, may have assumed this behaviour to be disinterest or passivity. Instead

of eliciting [the patient's] own values and family traditions prior to treatment, they may have assumed that he was willing to participate, and had no different expectations from the treatment.

Hannah analysed the doctor-patient interaction from the perspective of the patient and the doctor. She did this by deconstructing the interactions describing culturally situated behaviours, for example, a patient's lack of eye contact with a more educated person. Hannah's analysis suggested she was attentive to non-verbal cues and subtle signals, a critically important indicator of intercultural sensitivity and the ability to provide culturally responsive care. The ability to recognise multiple perspectives and reserve judgement indicated 'acceptance'. The ability to shift her frame of reference and try to imagine how the doctor-patient relationship may have been construed differently by each person demonstrated an initial phase in 'adaptation' (S5a). Being able to view a consultation from different perspectives and reconcile the differences are key skills in developing intercultural competence (Fitzgerald, 2000).

In her closing statement Hannah acknowledged the importance of reflection and inquiry to understanding patients' points of view and expectations. Hannah described the take-away lesson for the students as future physicians: "As doctors I think it will be important to reflect on, and inquire about the cultural context of our patient—their expectations, beliefs, and values, instead of making generalised assumptions". Hannah recognised the importance of learning from the patient and the danger of making assumptions; both realisations are crucial to a patient-centred approach (Betancourt et al., 2003; Danso, 2016; Fuller, 2003; Tervalon & Murray-García, 1998).

Hannah's post provided a good example of how 'practical reflection' (I.2) and analysis support intercultural sensitivity and an ethnorelative perspective. Hannah began by identifying the cultural dimension of power distance, which she postulated was the reason

for a breakdown in communication between the doctor and patient. She then analysed the doctor-patient interactions from the perspective of the Samoan patient and the Western doctor, suspending judgement about either perspective; a characteristic of the ‘acceptance’ stage. Hannah’s ability to imagine the doctor-patient interaction from a cultural perspective different from her own illustrated a ‘shifting frame of reference’, the initial phase in ‘adaptation’ (S5a), the fifth stage in the ethnorelative worldview (Bennett & Bennett, 2003; Hammer, 2011). Hannah then tried to imagine what may have gone wrong—that the doctor may have failed to solicit the patient’s views and values and assumed the treatment was agreeable to the patient. Finally, she drew a conclusion based on her analysis that it is important that doctors “reflect on and inquire about the patient’s cultural context...” and thus articulated the importance of being open to learning from the patient—a practical application for future doctors.

Hannah and Fabiana’s posts exemplified the progression in ‘practical reflection’ (L2) posts. Level 2 posts often began by identifying a cultural dimension, such as power distance or uncertainty avoidance (see Hofstede’s dimensions, Table 2, p. 95), that was evident in the actions of individuals depicted in the case and did so without expressing judgement. Students at L2 level then analysed the doctor’s and/or patient’s/family’s actions in relation to a specific cultural worldview. These students exemplified ‘acceptance’ in that they articulated differences and similarities in their own and others’ perspectives and recognised the different ways that culture or worldview influenced people’s behaviour and interactions (Hammer, 2011; Hammer et al., 2003). In addition, a few students at ‘practical reflection’ (L2) level, such as Fabiana, drew on personal experience to provide alternative explanations for the patient’s or family’s behaviour. Finally, ‘practical reflection’ posts often ended with a synthesis or evaluation by drawing a conclusion or hypothesising how

the situation could be handled differently, and how their insights might be applied to future practice.

A few of the 'practical reflection' (L2) posts, such as Hannah's, demonstrated the ability to engage in cultural empathy and shift frames of reference. For example, Hannah tried to interpret the actions of the patient/family and doctor and imagine how each participant perceived the situation, which is characteristic of cultural empathy, and also analyse where misunderstandings could have occurred. This is an example of shifting one's frame of reference, where one attempts to understand a situation from a worldview (or a set of constructs) different from one's own (Bennett & Bennett, 2003). The ability to cognitively shift one's frame of reference is a precursor to behaviour code shifting (S5b). Behavioural code shifting involves adapting one's behaviour based on an awareness of what is appropriate in a particular cultural context (Bennett & Bennett, 2004; Hammer et al., 2003).

Fabiana and Hannah's posts also illustrated how students with significant life experience in different cultures or countries appeared to have a readiness for intercultural learning. Fabiana was a Malaysian Chinese international student and Hannah was a New Zealander who had spent significant periods of time in three different countries. Fabiana was bilingual in Chinese and English and Hannah spoke four languages: English, German, Dutch, and Czech. Prior research indicates that students with prior intercultural experience have greater intercultural sensitivity compared with students who lack prior intercultural experience (Paige et al., 2003). In addition, students from bi or multicultural backgrounds or who have had significant overseas experience, appear to bring a readiness for intercultural learning (Taylor, 1994; Ziegahn, 2005). This readiness helps them to suspend judgement and recognise multiple perspectives (Taylor, 1994; Ziegahn, 2005).

## Intercultural sensitivity in a 'critical reflection' (L3) post

### *Recognises the importance of assumptions*

As mentioned in Chapter Five, only one post met the criteria of 'critical reflection' (L3). Raymond articulated a different concept of culture than his previously held belief and provided an explanation of his new conception: "What I'm increasingly becoming convinced of is that culture isn't so much something you belong to, but instead are the assumptions you make in your day-to-day activities and your way of thinking". Raymond's statement is reminiscent of Bennett's (1986; 1993) conception of culture as the way one construes events. Importantly, Raymond recognised how assumptions can limit a doctor's understanding of the situation in an intercultural consultation:

However, when encountering another culture, these assumptions break down. Sometimes this is extreme and obvious, such as a language barrier and the imperfect nature of translation, sometimes [they are] very specific circumstances, such as Mr. Kochi's objection to the pump based on his religious rituals... these assumptions remain a barrier to providing fully competent healthcare... The doctor's assumption that Mr Kochi and his family would be fully informed of the diagnosis (when Afghani culture [typically withholds bad news from the patient]) can be seen as an example of this.

Raymond's post exhibited acceptance in that he recognised that each person had a unique worldview (or set of assumptions) that influenced the way they viewed events and people's actions (the doctor who assumed the patient had been informed of his condition and the Afghani translator who withheld the bad news from the patient). Raymond concluded his post with the practical implications of the case:

The solution to these problems seems to be both an awareness of our own assumptions and perhaps a reductionist approach. When we know we're engaging with another culture, it seems dangerous to let anything pass unquestioned, especially if we



believe it's not in the patient's best interests. I'm not suggesting that the doctor should try to change the patient's beliefs, merely make sure that the patient's objection is in fact relevant to the situation and work to formulate alternatives...questioning and discussion on the part of the doctor must be used to ensure that no gaps are left for misunderstanding.

Raymond identified two important practice points. First, he stressed the importance of being aware of one's own assumptions, and second, he emphasised dialogue as a means to ensure understanding and clarify any misunderstandings. Becoming aware of one's own assumptions, values and beliefs is important in developing intercultural competence (Fitzgerald, 2001; Kumagai & Lypton, 2009; Lie, Shapiro, Cohn, & Najm, 2010; Wear, 2003). Assumptions can be a barrier to achieving a shared understanding between doctor and patient. Shared understanding comes by finding out what the patient knows or thinks, and listening carefully to the patient without judging them (Gray, 2014). Raymond also stressed that the doctor shouldn't try to change the patient's beliefs but rather, should understand the patient and "work to formulate alternatives". Patients are unlikely to share openly if they think the doctor will be judgemental of them (Gray, 2014). Raymond demonstrated an openness to learn from the patient, and humility when he recognised that it is easy to make assumptions that are incorrect when working with individuals from cultures that are different from one's own.

Raymond's recognition of the importance of dialogue to ensure understanding and working with the patient to find alternatives demonstrates an important component of patient-centred, culturally competent care; this strategy indicates an attitude of openness and inquiry in the doctor patient relationship (Danson, 2016; Fuller, 2003; Tervahauta & Murray-García, 1998). On one hand, openness and inquiry may mean questioning to ensure understanding. On the other hand, openness may mean negotiating a treatment

plan that both the doctor and patient/family can accept. Interestingly, Raymond was born in Scotland to Scottish parents; however, had lived in New Zealand the majority of his life.

## Summary

In this chapter, I have provided an overview and detailed description of students' intercultural sensitivity displayed at each level of reflection. While the majority of students at all levels of reflection displayed 'acceptance', an ethnorelative perspective, there were a few students who displayed a defensive stance, which is characteristic of 'defense' stage, an ethnocentric perspective. Students who displayed a defensive stance denigrated unfamiliar cultural characteristics and viewed their own culture as superior. One of the students who displayed a defensive stance, tried to view the clinical situation from another cultural perspective; however, the student maintained a judgemental stance toward the unfamiliar culture and viewed her own culture as superior. This post highlights how a person with an ethnocentric perspective can be in a transitional phase. They may attempt to look at a situation from another perspective but do so with the assumption that their own culture is best or 'correct'.

The majority of students at 'understanding' (L1) and 'practical reflection' (L2) levels viewed the intercultural cases from 'acceptance', an ethnorelative perspective. Students at L1 and L2 who viewed culture from the position of 'acceptance' were able to understand how individuals' behaviour was influenced by their worldview and was 'sensible' from a particular cultural context. In other words, actions were understood in the context of an individual's worldview or frame of reference. Some students at L1 acknowledged only one perspective, while other students recognised multiple perspectives (i.e., doctor, patient and/or family). Most students at L1 and L2 appeared to suspended judgement to try and

view a situation from another cultural worldview. However, L1 and L2 levels expressed acceptance in qualitatively different ways.

The qualitative difference between students at L1 and L2 was the ability of students at L2 to interpret new concepts related to culture in terms themselves. Students at L1 had difficulty interpreting the dimensions of culture, introduced in the unit, to themselves personally or to their future practice. It is possible these students had fewer prior experiences with people from different backgrounds and thus had less to draw upon to connect the cases to their own lives.

By contrast, students at ‘practical reflection’ (L2) level drew on personal experience to interpret dimensions of culture (e.g., collectivism/individualism). In addition, a few students at L2 level exhibited awareness of how their own cultural context had shaped their perspective, and identified how the cultural context might differ for particular individuals, which is characteristic of the ethnorelative worldview (Deardorff, 2006; King & Baxter Magolda, 2005; Shaw, Lee, & Williams, 2015). This finding indicates a relationship between reflection and students’ ability to interpret concepts of culture on a personal level by making connections to prior experience or articulating how understanding cultural differences will be important for their practice as doctors.

Two students at ‘practical reflection’ (L2) level also illustrated how reflection assisted them to engage in cultural empathy and shift frames of reference. These students exhibited the metacognitive skills to move beyond their situated perspective and engage in cultural empathy. They tried to imagine the clinical situation from another worldview. The ability to engage in cultural empathy and shift frame of reference is thought to be crucial to effectively accommodate differences in intercultural interactions (Deardorff, 2006; Taylor, 1994). Shifting frame of reference also represents the first phase of Adaptation (S5a) or the

ability to cognitively shift frame of reference, which is thought to be a precursor to adapting behaviour in culturally appropriate ways (Bennett & Bennett, 2003).

In the one 'critical reflection' (L3) post, the student recognised the importance of assumptions. This student discussed how a lack of awareness of one's own assumptions could be a barrier to understanding the patient and thus undermine their care. This student at L3 also articulated practice points including, trying to be aware of assumptions when communicating with a patient from a culture different to one's own, taking sufficient time to communicate with the patient and understand their perspective, and clarifying misunderstanding in order to work toward shared understandings and solutions.

The findings related to the relationship between students' levels of reflection and their intercultural sensitivity both confirm and contradict prior research. Similar to Ziegahn's (2001) study, the students in this study at 'understanding' (L1) level, or non-practical reflection posts, had difficulty interpreting new theories, (e.g., Hofstede's dimensions) in terms of their own life experience. However, in contrast to Ziegahn's (2001, 2005) research, students at 'understanding' level (L1) (i.e., non-practical reflection), as well as at 'practical reflection' (L2) level, recognised multiple perspectives. Some students at 'understanding' level recognised more than one perspective in the clinical cases, such as the case of the Afghan immigrant and his doctor. The patient's poor health outcomes illustrated the consequences of miscommunication due to cultural differences, and this may have encouraged students to try to understand the different perspectives of doctor and patient.

Another finding from this study that supports prior research findings is that students with significant overseas experience or exposure to other cultures and languages showed a readiness for intercultural learning (Taylor, 1994; Ziegahn, 2001). Examples included an international student from Malaysia and a New Zealand student who had significant

overseas experience were able to exhibit cultural empathy and shift their frames of reference by trying to imagine the perspective of individuals depicted in the cases. These examples suggest that the prior experience that students have with other cultures can impact their readiness for intercultural learning and their ability to make sense of intercultural encounters. As mentioned earlier, students at L1 may have lacked experience from which to draw on to interpret the intercultural clinical cases. Together these findings suggest a social construction of awareness of intercultural issues based on prior experience that students bring to their intercultural learning.

In the next chapter, I explore the factors that contributed to students' intercultural reflection online such as the use of clinical cases to contextualise learning about culture in medicine, characteristics of the asynchronous online environment, and the opportunities afforded for student-to-student and teacher-student interactions. I also examine factors that hindered intercultural reflection online including ineffective tutor facilitation, the design of the online activity, and students' approaches to and the public nature of online reflection.



# Chapter Seven

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**Factors that fostered or hindered  
students' reflection and  
participation online**





## Introduction

In Chapter Six, I examined the students' levels of reflection in relation to the intercultural sensitivity evident in their online posts. In Chapter Seven, I explore the factors that facilitated and hindered the students' online reflection and dialogue. Data for this chapter was drawn from the online posts and written anonymous feedback collected from the students and tutors at the end of the Culture and Health unit. Many of the students' quotes in this chapter lack names because they were drawn from the anonymous written feedback. This chapter is structured as follows. First, I provide an overview of the factors that encouraged or hindered reflection. I then discuss in detail the factors that promoted students' reflection and intercultural learning, before exploring the factors that hindered students' reflection and participation online. I conclude the chapter with a summary of the findings, and their significance for facilitating medical students' reflection and intercultural learning.

## Overview of the findings

In this study, there were clear advantages as well as disadvantages to using online discussions to promote students' reflection and intercultural learning online. On one hand, factors that contributed to students' reflection and intercultural learning included setting cultural concepts in a clinical context, and characteristics of the asynchronous online environment such as time to read and reflect before responding, and the opportunity the online discussions provided to write and interact online. On the other hand, several factors hindered students' online reflection and engagement with the task, including the design of the online task, the public and obligatory nature of online reflection, and the students' surface approaches to completing the online assignment. Tutors fostered reflection when they modelled reflective thinking online and asked questions of specific students; however,

most tutors did not actively participate in the online discussions, and their absence may have hindered reflection. In addition, tutors' use of general comments such as 'good job' or 'great reflection' to encourage students were not effective in facilitating students to reflect more deeply.

## **Factors that promoted students' reflection and intercultural learning online**

### **Exploring cultural concepts in a clinical context**

The intercultural clinical narratives in the reading material and documentary film created interest and encouraged reflection because they provided 'authentic', real-world situations that illustrated the impact of cultural differences in medicine. Specifically, the cases showed how cultural differences can pose challenges for the doctor-patient relationship, and lead to poor patient outcomes. Having to analyse where the breakdowns in communication occurred, or the reasons why patients or family felt differently from the doctor about the treatment plan, encouraged students to reflect on and apply concepts introduced in the course and their own knowledge to the clinical cases.

Many students found the documentary film about the Afghani migrant diagnosed with stomach cancer particularly compelling. Students were surprised that the doctor in the film did not discover until quite late that it was not religious beliefs, but rather issues around washing before daily prayer, that led Mr Kochi to reject the chemotherapy by continuous pump. This case illustrated to students how cultural differences and miscommunications on the part of the doctor could result in the patient not receiving treatment. For example, Dominick recognised how misunderstanding could undermine the doctor-patient interactions:

The film *Hold Your Breath* clearly highlighted the effects that cultural misunderstandings can have in the clinical setting and allowed me to gain a new understanding of what it takes to provide competent health care to those of a different culture. While language appeared to be the major barrier to competent health care, there were a number of other cultural issues hidden beneath the surface... It is imperative that not only treatment is discussed but all other relevant aspects of a patient's life are too. When treating someone of our own culture we discuss their social history therefore this same aspect of consultation should be applied to the culturally diverse.

The film helped Dominick recognise that language can be a barrier, and that doctors should not focus solely on cultural factors but also on exploring social factors affecting patients' lives and treatment choices. Dominick's insight about the need for taking a social history aligns with the literature that stresses the importance of understanding the patient's social context and how issues in the patient's social world can impact healthcare choices and behaviours (Betancourt, 2006; Green, Betancourt, & Carrillo, 2002).

The intercultural clinical cases also encouraged reflection because they challenged students' assumptions, which compelled them to examine different worldviews, perspectives, and beliefs. The students were surprised at the different views expressed about care of the body at death, decision making about treatment, and informed consent. This was valuable because these differences prompted students to reflect on their own worldviews and beliefs in comparison to those of the individuals depicted in the cases. For example, Bret, a student of Korean descent, commented on differences between his mother and the Korean wife who was unwilling to make end-of-life care decisions for her husband. Bret wrote:

This case is interesting because my mum would go psycho at me if I made such [an] important decision for my dad without involving my mum, and yet I'm a Korean. I

think it's important not to generalise everybody according to their culture as there's always outliers. Also, with time, cultures tend to change especially nowadays with the rapid Western influences everywhere.

This case encouraged reflection because it challenged Bret's experience as someone from Korean descent. The differences between the Korean wife in the case and Bret's own mother caused Bret to reflect on and compare the two mothers' different perspectives on end-of-life decision making. These comparisons led Bret to recognise the importance of not generalising about people based on their ethnicity. It also caused Bret to realise and articulate how culture is dynamic and how Korean culture was changing in response to Western influences. Bret's comment shed light on 'within culture' differences and provided contrasting worldviews.

### **Characteristics of the online learning environment**

Students' and tutors' feedback on the value of the online discussions suggested that the asynchronous online learning environment supported students' reflection and intercultural learning in three important ways. Firstly, the asynchronous nature of the online environment gave time for students to read through classmates' comments and reflect on the clinical cases before formulating their own ideas, and this encouraged reflection. Secondly, the need to write their online posts encouraged students to reflect and organise their thoughts before writing, which contributed to a more considered discussion than might have occurred orally in a real time class. Thirdly, online interaction with peers helped students recognise new perspectives, which, in turn, supported their reflection and intercultural learning. These findings appear to support the notion that the asynchronous online environment fosters internal thinking processes combined with external collaborative dialogue in ways that together support reflection and learning (Garrison, 2003; Warschauer, 1997). In the following sections, I explore these three aspects of the

asynchronous online environment that, in this study, fostered reflection and intercultural learning, and provide examples for each.

### *The asynchronous nature of online environment*

Approximately 20% of the students mentioned ‘unpressured time to think’ as a benefit of the asynchronous environment. The additional time associated with the asynchronous environment appears to have helped these students to consider the cultural issues and multiple perspectives more carefully than they might have in a face-to-face setting. For example, one student specifically compared the quality of the online discussions with tutorial discussions:

It was a good learning tool as we were able to complete the tasks in our own time outside of tutorials. We had the time... to critically analyse not only what we wrote but what our peers wrote, whereas in [the] tutorial often we just say the first thing that comes into our minds.

Students who said they benefited from the online discussion stressed that the asynchronous environment gave them time to consider the cultural concepts and different perspectives. For example, one student wrote, “[I had] time to think and form ideas ...; [it] made me contemplate the implications of cultural considerations in practice more.”

Similarly, another student wrote, “I enjoyed the forums...because I got the chance to think and...consider different perspectives.” A tutor’s comment also supports the notion that the online discussions encouraged the students to think more deeply: “I ... think [students] took their thinking to a deeper level—rather than just blurting something out verbally, they had to really think about what they were saying and how it would advance the discussion.” These findings support prior research that the asynchronous online environment promotes reflection by giving students more time to consider the ideas being discussed, review what others have said, and formulate their own ideas before writing a post (Curtis, 2006; Plack,

Dunfee, Rindflesch, & Driscoll, 2008). The online discussions provided additional time to reflect and consider the cultural concepts, and this is especially important given the time constraints that medical students typically experience (Thomas, 2013).

The more considered discussion online may also have contributed to students' learning about the impact of culture in medicine and the cultural concepts (e.g., power distance, uncertainty avoidance, etc.) introduced in class. For example, one student said, "I personally found the online discussions helpful. [The posts] were very insightful and in-depth which was really good for my learning about culture". In addition, students felt the online discussions improved their understanding of the cultural concepts introduced in the tutorial (e.g., individualism and collectivism). One student wrote, "[It] takes a lot of time to thoughtfully produce a legible post. But [it] did help solidify Hofstede's dimensions". Another student commented "[the online discussions were] quite a good way of integrating and learning Hofstede's [dimensions] and applying them to actual cases."

Comments from tutors also suggested that the online discussions supported students' learning. This was the first year that online discussions were used as part of the Culture and Health unit, and one tutor wrote, "I felt the difficult concepts [were a] wee bit better understood than last year". Another tutor, who compared students' understanding of Hofstede's (1980) dimensions online and in class said, "Students certainly applied Hofstede's dimensions well online—they had struggled in the tutorial". These findings concur with prior research that found that the online environment provides time for students to reflect on an issue, obtain more information, and give it more careful consideration before coming to a conclusion (Plack, et al., 2008). In addition, interaction online can help students to apply theory to practice and view a situation from different perspectives (Plack, et al., 2008).

### *Written reflection online*

Having to compose a post appears to have played an important role in the students' 'meaning making' processes and encouraged reflection and learning in multiple ways. One student captured this notion when he wrote:

Having to write a comment actually forces one to think a lot more than I usually do. I think it shows the importance of sitting down and putting your thoughts into words because it makes you take your reflection that much further.

The literature suggests that writing fosters systematic thinking as students think carefully about what they want to say and connect their ideas to concepts in the course (Scardamalia, Bereiter, McLean, Swallow, & Woodruff, 1989). Reflective writing also helps students develop and deepen their own personal understanding of ideas covered in the course and increases students' engagement (Moon, 1999; Vivekananda-Schmidt et al., 2011).

The permanent record associated with the online discussion was helpful to some students' learning and reflection but challenged others. One student remarked, "Having everything in writing... meant we could go back over points other people previously raised". This feedback supports prior research that indicates that the permanent record of the online discussion makes reasoning apparent by tracing students' lines of thinking and showing arguments, including how students' views changed as a result of others' comments (Lin & Lehman, 1999; Ziegahn, 2001). Despite the apparent benefit of the permanent record for some students, later in this chapter I explore how the public and permanent nature of the online discussion was also a hindrance for other students' reflection.

### *Peer interaction online*

Peer interaction online encouraged students to express points of view, negotiate meaning, and become aware of different perspectives. It also provided opportunities for

sociocultural learning. Exposure to alternative perspectives and the need to negotiate meaning is crucial for developing interprofessional teamwork skills, as well as intercultural competence, because it helps students recognise that alternative viewpoints exist and challenges their taken for granted assumptions about the world and people's actions (Barr, 2013; Kumagai & Lypson, 2009; Wear, Zarconi, Garden, & Jones, 2012). For example, students in my study expressed surprise that the same case could be interpreted differently by other students: "[It was] incredibly useful to hear other people's reflection ... They have watched or read the exact same thing as me, but may have gotten something completely different out of it". Students also recognised the value of learning from peers from other cultures, saying, "It was interesting to see what [students] from different cultures had to say".

Like the HIV/Aids healthcare workers in Curtis's (2006) study, when students in this study encountered classmates' ideas that were different from their own it caused them to re-examine what they thought and explore new ideas. Discussion with peers online created doubt or cognitive dissonance and contested students' perceptions about a case both of which encourage reflection (Dewey, 1933; Mezirow, 1990). Interaction with peers helps students recognise the unique, situated perspectives they bring to the clinical encounter (Wear et al., 2012). For example, in the current research, an online discussion ensued about the Afghan migrant in the documentary film, who was diagnosed with stomach cancer. Mr Kochi was angry with the medical team and this prompted an online discussion about the reasons behind Mr Kochi's anger. Doug began the discussion by posing a question in response to a classmate who had suggested that medical appointments should not conflict with Muslim prayer time:



One of the ways you've suggested that patient care could've been improved was by making "appointment times that won't interfere with prayer time". I'd like to generate some discussion on this point.

Prayer is an important activity for followers of the Islamic faith. What about patients who have other commitments which have nothing to do with religion? For example, keen badminton players who don't want to miss their games. ... Is it somehow more important to respect religious activities than nonreligious ones? If so, why?

Doug's comment prompted Dajana, a Muslim student, to clarify Muslim prayer requirements,

... I do not think Mr Kochi's actual problem was missing a prayer; in Islam you can pray wherever you are as Mr Kochi did in the end and the activity takes less than 5 minutes (the idea is for it not to be burdensome).

Dajana continued by explaining what she thought was the reason for Mr Kochi's anger with the medical staff:

[Prayer] wasn't the real problem. I think [Mr Kochi] expressed his real concerns when he said "every patient should be treated like an emergency". I think Mr Kochi felt underappreciated by the system. They lost his x-rays, [the doctor] laughed at him when he requested something for his throat. This was only compounded further by the fact that he had expectations for his treatment based on his cultural perspective- [as] 'the head of the family'... I think he was greatly disappointed by the whole ordeal and used this situation as an opportunity to vent his frustrations.

Doug responded to Dajana's post, indicating she voiced a perspective he hadn't considered,

...wow, what an eloquent reply! I agree ... I think your suggestion that "Mr Kochi felt underappreciated by the system...and used this situation as an opportunity to vent his frustrations" is very perceptive; it hadn't occurred to me at all.

This excerpt illustrates how interactions online provided opportunities for students to view the clinical encounters from different perspectives and fostered reflection and sociocultural learning. Dajana provided an opportunity for sociocultural learning when she clarified the requirements for prayer and offered an alternative reason for Mr Kochi's anger. Doug acknowledged that it hadn't occurred to him that Mr Kochi was angry about the way he'd been treated by the doctor. Doug and Dajana negotiated meaning as they asked thought-provoking questions, clarified concepts, expressed their points of view, and considered alternative interpretations. Students can increase their understanding of other cultures and develop awareness of people's situated perspectives through discussion with peers (Wear, Kumagai, et al., 2012). In addition, when students express views that contradict what peers think, it can encourage them to re-examine their beliefs and explore new ideas (Palincsar, 1998). Collaborative online discussions, such as the one described here between Dajana and Doug, encourages students to express their point of view and also to 'de-centre' or step back and become aware of alternative viewpoints (Clark, 2009; Wear, Zarconi, et al., 2012). Exposure to alternative perspectives forces students to negotiate meaning and learn from others, which is not only important for their interactions with patients but also for working in interprofessional teams (Barr, 2013).

There was evidence that students gained new insights into cultural differences when peers shared their insights based on their personal experience of a particular culture. For example, Morley drew upon his Pacific background to clarify the meaning of the term 'family',

... from my experiences, the Pacific Island use of the term 'family' tends to be inclusive of cousins, aunts, uncles and grandparents (and even more than this). This is why when the term family was used in this [case], I do not believe it was just the man's children and wife, but rather it was inclusive of a much wider group of people,

therefore demonstrating a collective approach, rather than an individualistic [approach].

Morely's comment prompted Raquel to recognise that there may be different meanings associated with the word 'family': "I thought the comment you made about the different meaning of family was useful. It is important that we realise that things can have very different meanings and hold different values in different cultures". Raquel's reply illustrates how interaction with peers can foster sociocultural learning that involves changes in students' current understanding and stimulates new insights (Palincsar, 1998; Vygotsky, 1978; Wink & Putney, 2002). Raquel's reply also shows how dialogue with peers can help students scrutinise their own beliefs and recognise that they bring a situated perspective to the intercultural encounter (Wear, 2003).

These findings support prior research that stress the value of reflection within community. Firstly, students appreciate learning about culture in medicine from their peers from different backgrounds (Roberts, Sanders, Mann, & Wass, 2010). Secondly, medical doctors do not work in isolation but rather in teams. Working in a team requires two types of reflection. The first is the ability to reflect on their own thoughts, values and perceptions of a situation, and second a metacognitive ability to step back and recognise alternative viewpoints (Barr, 2013). Consequently, reflection in community can be especially important because it exposes students to alternative perspectives and this facilitates growth (Kumagai & Lyson, 2009; Mezirow, 1990; Wear, Zarconi, et al., 2012). Further, the insights shared online by diverse students within the group challenged simplistic notions about 'others' (e.g. Brett's contestation of 'the Korean view').

## Effective tutor facilitation

Although the majority of tutors did not actively participate online; there were a few who did participate and facilitated students' reflection when they drew upon personal experience, modelled reflective thinking, and challenged students' assumptions. The academic literature suggests that effective tutor facilitation is underpinned by a non-hierarchical relationship between tutor and student (Bearman & Molloy, 2017; Jones & Ryan, 2014; Kumagai & Lypson, 2009). Tutors who position themselves in reciprocal relationships to their students in that they are open to sharing personal experiences can help establish a trusting environment that facilitates reflection (Bearman & Molloy, 2017).

Further, it is crucial that tutors model critical reflection (Jones & Ryan, 2014; Wear, Zarconi, et al., 2012) and direct questions to individual students rather than the group to foster reflection and learning (Means, Toyama, Murphy, Bakia, & Jones, 2009). In this section I describe how the tutors effectively facilitated practical reflection and challenged students' assumptions in this study.

### *Modelling reflective thinking and asking questions of specific students*

The tutors who modelled reflective thinking and asked questions of individual students illustrated the important role tutors can play in facilitating reflection. Marge, a tutor who was born overseas, modelled reflective thinking by drawing on personal experience, asking questions of individual students, and affirming students' practical reflection posts. For example, Marge responded to a student's post about the Korean case that dealt with decision making. She asked, "...who in your family or people you are familiar with...makes the health-based decisions"? Marge then modelled reflection by drawing upon her own experience to explain how health-based decisions were made in her home country:

People from [my country], like the Italians, tend to wait for someone to tell them to go and consult the doctor. There is a level of feeling unloved if nobody tells you that you are sick and need to be looked after. Often in Western families it is the woman of the house who makes many of the everyday decisions about health.

Marge's question prompted Andrea to share about her Chinese family's history with illness and how it was similar to the Korean case of the wife who was unwilling to make end-of-life decisions about her husband's care.

Coming from a Chinese background that is somewhat similar to the Korean cultural traditions, I can identify with the situation in case 2. When my grandmother was hospitalised several years ago, it was my dad (the oldest son) who made the medical decisions. I guess it was partly due to my dad being seen as the most knowledgeable in the family but also because it's assumed that the eldest son has the responsibility of having to care for his elderly parents, which includes making medical decisions and paying for the hospital bill. In [this] case, it might have been that the Korean woman didn't feel that she was knowledgeable enough to make an informed choice or that she wasn't the one with the responsibility of having to pay for the medical fees, thus it wasn't her decision to make.

When Marge modelled reflection that drew upon personal experience and situated 'Western' families as culturally located, she provided an example for Andrea to engage in practical reflection (L2). Prior studies indicate that tutors who model reflection and share their personal experiences, give students an example that they can then use to engage in reflection (Bearman & Molloy, 2017; Perlman, Ross, Christner, & Lypson, 2011).

Apparently following Marge's lead, Andrea demonstrated the ability to personalise her learning by relating the case to her own experience. When students bring personal meaning to the concepts being discussed, it can help them to construct knowledge and reach a personal understanding of complex situations (Boud, 2010). Andrea's comment prompted

Aelia, a New Zealand classmate, to express an alternative perspective on the same case, describing a New Zealander's perspective:

To a native New Zealander brought up in [a culture that] Hofstede may describe as 'low Masculine' ...[the Korean wife's perspective] does not fit with role of feminism we have been brought up with, but the wishes and beliefs of the patient and family must be respected.

Marge responded to Aelia, "Good comparison and very good in terms of reflective practice to bring in your own experience". Marge's online facilitation underscores the importance of not just commenting on the content of students' posts but also their process in order to facilitate reflection in students (Mann, Gordon, & MacLeod, 2009). Marge responded by mentioning Aelia's comparison of cultures and Aelia's process of drawing on her own experience. When tutors model reflective thinking by drawing on personal experience, comment on students' posts, and ask questions of specific students they increase the likelihood that the students will reflect and ensure that valuable concepts are explored (Swan et al., 2008). In addition, by affirming a student's process of reflection, they can gain a conceptual understanding of reflection that is based in their own practice (Brockbank & McGill, 2007).

### *Challenging students' assumptions*

Tutors can also facilitate practical reflection by challenging students' assumptions. In the current study there was one example where a tutor challenged his students' thinking and encouraged them to examine their assumptions in order to facilitate both practical reflection and intercultural learning. It is difficult for students to be aware of their own assumptions because they use their "own personal, interpretive filter to become aware of [their] own interpretive filters" (Brookfield, 1998, p. 197). Students need other viewpoints to help them see their own thinking and/or actions in a different light (Brookfield, 1998).

Consequently, it is important that tutors encourage students to question their own assumptions and contemplate different perspectives (Kumagai & Lypson, 2009).

Gordon, a tutor in the current study, questioned his students about their interpretation of power distance in the Korean case. His students had been very critical of large power distance cultures, and as mentioned in Chapter Six, some students described large power distance relationships as reflecting “out-dated beliefs” and “making no sense”. Gordon began by noting a student’s criticism of power distance, “Hmm very interesting. John has been rather critical of the power distance within Korean culture”. Gordon then asked:

I guess I have two questions ... Firstly, these Korean cultural habits [may be] very long standing. It would seem unlikely for a culture to adopt such a specific code of social discourse unless it has some utility. We do need to try to get past our own assumptions when studying other cultures. So, are there any benefits for society in having a large power distance?

Gordon then noted that power distance exists within medical culture and asked the students to consider the benefits and drawbacks of large power distance:

Secondly, medical practice is also known for its [large] power distance, otherwise known as the medical hierarchy, where junior doctors do not openly question the decisions of those 'further up the food chain'. Largely, this is also quite stable within medical circles. What are the pros and cons of this particular social arrangement? ... If this is changed, what would medical practice look like?

Gordon’s question prompted one student, Max, to re-examine his assumptions. Max began by acknowledging that he had initially agreed with his classmates, but then began to question his previously held ideas when challenged by Gordon:

I think this is a very interesting case and equally as interesting is how we interpret it. For example, Elise has written that it “seems to bear no sense” and seemingly disagrees

with large power distance relationships... At first I completely agreed with you, this power distance relationship seems so foreign to us...But if you think about it (as Gordon has alluded to) Western society also has many large power distance relationships which are completely accepted such as that of the medical hierarchy. The difference here might well be that such a relationship is essential as patients require the knowledge and education of medical practitioners to allow for the best decisions to be made. But this could be said for the Korean situation as well - perhaps the husband, eldest son and priest are roles in the Korean culture which typically gain the highest level of education?

Max recognised that large power distance relationships do exist in Western society and acknowledged why large power distance in medical hierarchy is useful. Max then admonished his classmates to consider an alternative perspective:

I think for any circumstance where we come across values which contradict so strongly with our own, it's imperative that we take the time to bypass our initial thoughts of disagreement and consider why their culture is the way it is, and therefore think about how we can embrace aspects of our patients' culture in order to provide the highest level of ... care.

When Gordon provided the medical hierarchy as an example of large power distance relationships, he helped Max recognise that there can be value in large power distance relationships. In addition, Max realised the importance of suspending judgement when coming across values that conflict with his own. Both Gordon and Max portrayed Korean culture in very static ways, even though they reflected on 'Korean' practices in ways that might inform medical practice productively. Questioning one's own assumptions is difficult, and students benefit when tutors challenge them to recognise alternative perspectives and identify how their views or assumptions may be limited (Brookfield, 1994; Mezirow, 2000).



Marge and Gordon's interactions with their students online illustrated effective online facilitation. Maintaining a facilitator role that is less hierarchical and more a co-contributor is crucial, because it helps tutors create an environment where students feel safe to share their perspectives, encourages dialogue and facilitates recognition of alternative perspectives (Bearman & Molloy, 2017; Jones & Ryan, 2014; Kumagai & Lypson, 2009). As a facilitator, the tutor attempts to eschew the authority and power inherent in the teacher role, and enters the discussion as a co-learner along with their students (Brockbank, & McGill., 2007; Kumagai & Lypson, 2009; Wear, Zarconi, et al., 2012). When tutors take on a co-learner role, students are encouraged to take responsibility for their own learning rather than expecting the teacher to be the source of knowledge. Effective facilitation and encouraging an environment in which students feel comfortable to explore multiple perspectives helps students engage in practical reflection (L2) (Bearman & Molloy, 2017).

The findings in this study support prior research which suggests that tutors play a crucial role in moderating and directing online discussion (Garrison & Cleveland-Innes, 2005; Swan, 2005) by posing questions that encourage deeper levels of reflection (Branch & Paranjape, 2002; Jones & Ryan, 2014), and motivating students to re-examine their own and their classmates' views about cultural differences (Ziegahn, 2001). Unfortunately, in the current study the majority of tutors did not actively participate online, and this may have hindered students' reflection and participation. In the remainder of the chapter, I discuss this and other factors that hindered practical reflection in students' online discussions.

## Factors that hindered students' reflection and participation online

In this section I explore factors which hindered students' reflection and engagement online. These factors included ineffective tutor facilitation, lack of tutor participation, the design of the online activity, students' surface approaches to the online task, and the obligatory and public nature of the reflective discussion online.

### Ineffective tutor facilitation

A few of the tutors who participated in the online discussions made vague comments or gave indiscriminate praise that did not foster reflection in their students. For example, one tutor commented, "Good work, [I] look forward to reading more comments from the group". This was the only comment this tutor posted. While the tutor may have intended to encourage more students in the group to contribute, their comment was not specific enough to indicate why the posts were 'good' or what kind of comments represented 'good reflection'. Instead, the comment may have incorrectly led students to assume that they had reflected and done what was required for the assignment. To be effective, tutors should provide timely feedback that is specific and/or comments on the process or content of a student's post (Cantillon & Sargeant, 2008). In addition, skilful facilitation involves asking 'why' questions that can encourage students' understanding, as well as careful listening in order to pick up on thoughts and feelings and then follow up with questions (Branch & Paranjape, 2002; Eva & Regehr, 2008).

Further, the tutors did not always accurately assess their students' levels of reflection, and this may have inadvertently confused students about what constituted reflection. For example, one student listed behaviours exhibited in the clinical cases and labelled these behaviours based on Hofstede's (1980) cultural dimensions, for example, respecting the

doctor as superior (power distance); seeking traditional herbal treatment (high uncertainty avoidance), etc. The student's post identified Hofstede's (1980) dimensions in the actions of individuals in the case; however, the post met the criteria for understanding (L1) not practical reflection (L2). Nevertheless, the tutor replied, "Yudong, great reflective depth..." This tutor's lack of clarity about what constituted reflection could have led to confusion among the students. Again, the tutor's comment may have led the student to think he was engaging in reflection when he was only demonstrating an 'understanding' level (L1).

### **Lack of tutor participation**

In addition to ineffective facilitation online, tutors' absences from the online discussions may have hindered students' reflection because the students lacked constructive feedback on their online posts. Due to busy clinical schedules, tutors were asked to 'monitor', and if need be, redirect the online discussions if they went off track. The majority of the tutors (seven of the twelve) in this study did not actively participate in the online discussions. Most of the tutors reported that they monitored the online discussions but did not add to them. For example, one tutor explained, "I read all the students' input and kept tabs on [the discussions] but did not contribute to the discussion myself". The lack of tutor facilitation meant that students did not receive feedback on their reflection in the online posts, and thus may not have known whether they were engaging in practical reflection. Prior research indicates that the presence of a tutor does not necessarily mean students will reflect more deeply (Jones & Ryan, 2014). However, Ryan (2013) suggests that tutors need to recognise different levels of reflection in students' comments and then, through skilful questioning at each level, move students to deeper levels of reflection. Lack of tutor participation means that students lacked feedback on reflection that was done well or when it was done poorly (Cantillon & Sargeant, 2008), which in turn could limit their learning from the activity.

Lack of tutor participation in the online discussions may have influenced how students viewed the online activity and/or the value of reflection and intercultural learning. For example, one tutor who merely monitored the online discussions thought that the in-class discussions produced more reflection: “[I] just participated by reading the discussions rather than adding to them. I felt that the students were more reflective in the class discussions than online”. A tutor’s attitude toward the topic being taught and/or the method of teaching can influence whether the students value the topic or the method of learning and teaching (Blakey, 2016). For example, Blakey (2016) found that if academic staff do not value reflective thinking, students tend to think reflection is a useless activity. This means that if tutors do not value the usefulness of the online discussions, students are not likely to consider it a valuable professional activity (Gray & Tobin, 2010).

## **Design of the online activity**

In addition to difficulties with tutor facilitation and participation, it appears the design of the online task may also have hindered students’ participation and reflection. The design of the week one online activity was problematic in several ways. Firstly, the week one online activity was too similar to the in-class discussion that preceded it. Consequently, some students felt the online discussion was a rehash of ideas. One student wrote, “I didn't find [the online discussion] to be that useful, especially as most of what was discussed online we had already discussed in class.” Another student felt the focus on Hofstede’s (1980) dimensions in the first assignment limited discussion:

The first [discussion] ... did not have enough scope to be very valuable... the emphasis placed on Hofstede’s dimensions... limited the conversation to ...where [individuals were] placed [on] a particular dimension rather than reflecting on the difficult problem of cultural values.

The week one activity asked students to apply Hofstede's (1980) dimensions of culture to the behaviours depicted in a particular case. This activity was not effective in moving students to deeper levels of reflection because the task required recall and comprehension rather than analysis and synthesis, which would have been more conducive to promoting reflection. Research suggests that the tasks or questions asked of students greatly influence students' level of cognitive engagement, and hence reflection, in online discussions (Arnold & Ducate, 2006). Students are more likely to move beyond identification and exploration of ideas to deeper levels of reflection when they are asked to focus on a particular issue (Jones & Ryan, 2014) and consider the practical application of their learning or work toward a shared goal (Garrison & Arbaugh, 2007).

It was evident from one student's comment that the first assignment was not effective in promoting discussion: "I felt confused by the online 'discussion' because while it was called a discussion... it ended up just a long list of opinions with little interaction, argument, or investigation into different opinions". Consequently, it appears that for some students the online activity was not successful in promoting a dialogue in which students built upon and synthesised ideas introduced in class. The data suggest that both the design of the online activity and the lack of effective tutor facilitation contributed to a discussion that, in many cases, did not move beyond what Garrison and Arbaugh (2007, p. 163) describe as "serial monologues" or "personal declarations". These findings reinforce recommendations by Means et al. (2009) that both effective facilitation and good curricular design are crucial for effective online learning.

Finally, the requirement for students to limit their posts to 200 words or less may have inadvertently prevented them from moving to deeper levels of reflection. As described in Chapter Four, the practical reflection (L2) posts appeared to include a progression of steps within the post. These L2 posts often began by describing the central conflict in the case,

then identified the relevant cultural dimension (e.g., power distance, short-term orientation, etc.) and related the dimension to the behaviours of the doctor, patient and/or family. Following this, the students made inferences about how or why the case was significant to them and then related their insight to prior experience, prior learning or applied it to their future practice as doctors. Limiting the length of the posts may have inadvertently prevented students from moving beyond the identification and application of the cultural dimensions because they needed to limit the number of words. One student noted the word limitation at the beginning of her post, “I have no idea how you’re supposed to say anything much in less than 200 words...” (Hannah). Interestingly, the average number of words per post was between 159 (week one) and 169 (week two) (see Table 3, p. 114). Therefore, 200-word posts may not be a sufficient length for students to engage in more in-depth reflection that involves analysis and synthesis of ideas. Prior research suggests that limiting word count, and what students can draw upon to substantiate their ideas (e.g., course readings), limited students’ engagement in more complex and meaningful discussions online (Gilbert & Dabbagh, 2005).

### **Students’ surface approaches to online reflection**

The students’ feedback suggested that some of them took a surface approach to the online assignment, which was not conducive to reflection. Rather than taking time to consider the implications or practical applications, some students took a passive, unreflective approach doing the minimum needed to complete the task (Trigwell & Prosser, 1991). For example, one student said, “I just made a post on what I thought the task [required] rather than trying to express my own thoughts”. Students also recognised that some of their peers were doing the minimum necessary for the assignment, for example, one student commented, “I ... think some of us just wrote things to meet the comment and response terms...”. Another student commented, “Sometimes you... only get cliché responses if

people aren't putting much time in—[they] sound rehearsed, a bit flippant. [It] takes a lot of time to thoughtfully produce a legible post”.

Students who take a surface approach focus on completing the task rather than trying to reach an understanding of the material (Entwistle, 1996). Prior research has found that students' ability to engage in reflective learning is related to their preferred approaches to the learning task, and their perception of the learning goal (Sobral, 2001). The competing demands of the medical programme may have meant that students placed a higher priority on learning biomedical knowledge rather than prioritising time for reflection on the psychosocial aspects of medicine highlighted in the Culture and Health unit. Prior research findings indicate medical students can be reluctant to engage in learning about cultural issues related to medicine because they do not see its importance to clinical practice (Hamilton, 2009). In addition, students' prior experience, frames of reference, and preferred learning approaches influence their ability to 'notice' differences, and this acts as a filter that either helps or hinders their ability to reflect on new concepts (Moon, 1999). The medical students who were intercultural novices may have had fewer experiences to draw upon when reflecting on the cultural concepts in medicine.

### **The obligatory nature of the online task**

The fact that the online discussions were a required activity appears to have hindered some students' reflection. First, engaging in reflection and considering alternative perspectives is personally demanding, and writing a thoughtful post takes time (Bolam, Gleeson, & Murphy, 2003; Lincoln, Stockhausen, & Maloney, 1997; Smith, 2011). As noted earlier, busy medical students may think learning biomedical knowledge and skills are more important, and consider the requirement to reflect a hindrance (Smith, 2011). This can lead to resistance to reflection. For example, one student wrote, “The... obligatory nature of

the posts subtracts from their quality”. In addition, if the value of the online discussion is unclear and the task is not compelling for students, they may just do the minimum work. For example one student commented, “I wouldn’t read anyone else’s posts after I posted mine. [It] felt like a chore. I don’t feel reflecting online helps that much”.

These findings echo Boud and Walker's (1998) assertion that just because you ask students to reflect doesn't mean they will reflect or learn in meaningful ways. Reflective assignments need to stress the connection between the reflective activity and learning outcomes (Boud & Walker, 1998). Students may resist reflective activities if they do not view reflection as related to their learning needs, and thus perceive reflection as ‘busy work’ (Pearson & Heywood, 2004). Interestingly, in a study of medical students’ perceptions of learning reflective skills, students observed that their peers who complained about having to reflect were the same students who would most benefit from reflection (Vivekananda-Schmidt et al., 2011). These observations suggest that, the way a required reflective activity is framed by the tutor, and the quality of guidance and feedback students receive, will influence their attitudes towards and engagement in the reflective activity.

## **The public nature of online reflection**

The public nature of online discussions clearly hindered some students’ reflections. Prior research indicates a tension between public and private reflection, with students reluctant to share feelings if they know their reflection will be read by others (Vivekananda-Schmidt et al., 2011). This sentiment was expressed by students in the current study. For example, one student aptly described the differences between a reflective template, which is a guided written reflection task and online discussion: “The difference lies in discussions being public and in a group, while [the] reflective template [is] individualised and private. Often I like to be private. Private reflections are freer...”. This student’s association of reflective



templates with freedom and openness was echoed by another student: “I think the reflective template is also good, [when] you don't expect others to reply, [you are] probably more open”. These comments suggested that some students may have censured what they said online because they knew their posts would be viewed by peers: “Having others read [my post] made me more conscious of what I could write”. Another student expressed discomfort that her posts would be scrutinized by her peers, saying, “I do not enjoy writing online where everyone can view my posts, as I feel I will be judged or my writing isn't ‘good enough’.

These comments echo concerns raised in the academic literature about questions of privacy and authenticity in relation to reflection in a public space such as online discussions (Hargreaves, 2004; Ross, 2012; Vivekananda-Schmidt et al., 2011). The public nature of online reflection can create uncertainty in students as they question whether their insights and experiences are valid (Hargreaves, 2004). This, in turn, can make students less candid and more strategic about what thoughts and experiences they wish to share (Ross, 2011). Asking students to reflect online raises the issue of how to create safe spaces where students trust one another enough to be candid in their online reflections. In addition, students quickly develop the ability to determine what is acceptable to say in different settings. If students feel their reflections are being assessed by the tutor, they will present views they think are valued by the instructor (Hargreaves, 2004). This presents challenges and barriers to authenticity when asking students to reflect in a public space (Ross, 2012).

## Summary

In this chapter, I explored the factors that encouraged or hindered students’ reflection, and intercultural learning in the current study. Factors that encouraged reflection and intercultural learning included the use of clinical cases for students to explore the impact of

culture in medicine, discussion with peers online, and the time lapse and written and interactive characteristics of the asynchronous online environment. Factors that hindered reflection and intercultural learning included the design of the online activity, including what was asked of students, limiting the word count, and similarity to the tutorial discussions. In addition to the online task, other factors that discouraged reflection were students' surface approaches to the online activity, the obligatory nature of the online assignment, and the public nature of online reflection. The influence of tutor facilitation on students' reflection and participation was mixed. Good questioning and modelling of reflection on the part of tutors encouraged students' reflection; however, lack of participation and vague comments did not encourage students' reflection.

The use of clinical cases for students to explore the impact of culture in medicine was an effective curricular strategy because the cases showed how real people could be adversely affected by miscommunication and misunderstanding due to cultural differences. Students were encouraged to reflect because they wanted to determine where the breakdowns between doctor and patient/family had occurred. The cases also surprised students and challenged their assumptions, which encouraged them to reflect. Through individual reflection and interaction with peers online, students examined their own worldviews in comparison to those depicted in the cases, and the worldviews expressed by their peers. When peers drew upon personal experience to clarify meaning or challenge their peers' perceptions, they encouraged sociocultural learning and recognition of multiple perspectives in their classmates. As a result, students developed awareness of their own cultural lenses in relation to their interpretation of the case, and began to see how cultural concepts introduced in the unit applied to future clinical practice.

The asynchronous and collaborative nature of the online discussions supported students' reflection in several ways. The additional time associated with asynchronous discussion

gave students time to read and reflect on the cases, and on what peers or tutors had posted, before formulating their own views. The online discussion also provided a written record that students could go back to and review. Some tutors and students reported that communicating online compelled students to think more carefully about the cultural concepts than they did in the tutorial. In addition, peers brought up ideas that students had not considered and this led them to re-examine their interpretations and think through the cases more thoroughly.

Interaction with peers online exposed students to alternative views on the clinical cases. Despite whether students liked or disliked the online discussions, their feedback consistently emphasised that the main benefit of the online discussions for their learning was exposure to different perspectives. Students said they gained new insights and enjoyed learning with and from their peers about how other cultures viewed health. Recognition of other worldviews and/or alternative perspectives is crucially important for encouraging the development of intercultural competence (Bennett, 2004; Deardorff, 2006).

The influence of tutor facilitation on students' levels of reflection was varied. A few tutors encouraged reflection when they focused their questions on individual students, modelled reflection by drawing upon personal experience, and challenged students' assumptions. However, vague comments, such as "good job" or "interesting comments" made by tutors did not encourage reflection. Furthermore, tutors may have inadvertently reinforced 'understanding' (L1) rather than 'practical reflection' (L2) by making inaccurate observations about the quality of students' online reflections. The lack of tutor participation online may also have led some students to view the online discussions as unimportant.

Students' feedback on the value of the online discussions was mixed. Those who did not feel they benefited from the online discussions thought that the issues discussed online

were redundant, because they repeated topics previously discussed in class. In addition, students said the week one assignment, was too narrowly focused on Hofstede's dimensions and thus did not facilitate discussion. Some students also felt the obligatory nature of the reflective assignment detracted from its usefulness. The students' mixed responses highlight the challenge of providing a rationale for online reflection that motivates a diverse group of students to engage in the activity in a meaningful way.

Students' feedback indicates that some students took a surface approach to the online assignment. These students appeared more concerned with doing the minimum to complete the task rather than trying to reach a personal understanding of the cultural concepts and engage in reflection. This could have been due to competing demands for students' time which caused them to prioritise learning biomedical knowledge over reflection and the psychosocial aspects of medicine. It could also have been due to students' lack of prior intercultural experience and frames of reference, which limited their ability to recognise cultural differences and influenced their ability to reflect on cultural concepts.

The public nature of the online discussions appears to have limited some students' online reflection. A few students said they were more comfortable expressing themselves in private reflections and indicated that they felt inhibited writing for a public audience. This finding illustrates some of the shortcomings of online reflection described in the literature. Asking students to reflect online may raise their concerns about privacy, authenticity and the risks associated with reflecting in digital space (Ross, 2011).

In the next chapter, I conclude this thesis by reviewing the findings and clarifying the contribution this study makes to our understanding of the relationship between students' reflective thinking and their intercultural sensitivity. I also consider the benefits and drawbacks of using asynchronous online discussions to foster reflection and intercultural

learning in medical students based on the study overall. In doing so, I identify some limitations of the study, and some avenues for future research.



# Chapter Eight

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## Discussion and Conclusion





## Introduction

In this chapter, I provide an overview of the study and present key themes emerging from this study, their contribution to the research field, and their relationship to the literature. I also explain the limitations of this study and discuss its implications for facilitating reflection for intercultural learning in a medical context. I then suggest future directions for research on reflection and intercultural competence in a medical context. I conclude by reiterating the research questions and the central findings of the study.

## Overview of the study

This study contributes to our understanding of the relationship between students' levels of reflection and intercultural competence in second-year medical students. The study brought together two frameworks to examine the relationship between students' reflective thinking and their intercultural sensitivity, a component of intercultural competence. Only a few studies have examined students' reflection as they investigate cultural differences, and none of those were in a medical context. This study contributes to theory by providing some evidence of a relationship between students' levels of reflection and their intercultural sensitivity. The study also contributes to practice by providing insights on the use of asynchronous online discussion to encourage reflection and intercultural learning in medical students.

I examined students' levels of reflection in two online discussions and explored what their reflections revealed about their intercultural sensitivity—that is, their ability to notice cultural differences, analyse their impact, and articulate strategies for effective intercultural interactions. Engaging students in reflection is necessary to improve learning, foster reflective practice and prepare students to work effectively with patients and in interprofessional teams (Barr, 2013; Kember, 2008; Ryan & Ryan, 2013; Wear, Zarconi,

Garden, & Jones, 2012). Through reflective processes, students can better understand themselves, and consider clinical situations with their future practice in mind (Sandars, 2009). Reflecting in community helps students to express ideas and negotiate meaning when they are confronted with new viewpoints that contradict their own (Barr, 2013; Clark, 2009). Learning to step back and gain perspective on their assumptions is also important preparation for working in interprofessional teams (Barr, 2013). In addition, reflecting online with peers about the intercultural clinical cases provided an opportunity for students to engage in reflection-for-action and help prepare them for their future practice as doctors (Ong, 2011)

Reflection is also considered important for the development of intercultural competence in medicine. Reflection helps students recognise that they bring unconscious assumptions and biases to their work with patients (Wear, Kumagai, et al., 2012). Reflective capacity is closely related to a) attitudinal skills that help us to suspend judgement (Bennett, 2004; Deardorff, 2006); b) metacognitive skills to view a situation from another perspective (Blasco, 2012; Stier, 2006); and c) emotional skills to identify our feelings and understand how they impact our actions (Stier, 2006; Byram, 1997; Gudykunst & Kim, 2003).

In this study, students engaged in two online discussions about the impact of culture in a medical context. I adapted a reflection framework that is recommended for analysing students' written reflection (Kember et al., 2008). Firstly, I analysed students' levels of reflection in the online discussion posts. Secondly, I analysed the intercultural sensitivity evident at each level of reflection. Finally, I identified the factors that contributed to or hindered students' reflection and intercultural learning. Together these findings contribute to theory by providing some evidence of a relationship between students' reflective thinking and their intercultural sensitivity. This study also contributes to practice by adding

to the literature on the value of online discussion to foster medical students' intercultural learning and reflection.

## Key themes

### Students' levels of online reflection

This study provides evidence that medical students who are early in their undergraduate professional education find it challenging to engage in reflection about culture in a medical context. This is evidenced by the fact that the majority of posts in this study were at 'understanding' level (L1), or non-practical reflection level; only one post was at critical reflection level (L3). Posts at L1 varied in complexity, with some posts identifying only one perspective (e.g., the patient's) and other posts identifying multiple perspectives (e.g., the patient's and doctor's). Some posts provided simple comparisons, identifying a cultural dimension and applying it to a person's behaviour. Other posts involved more analysis, including exploring people's beliefs or underlying conceptual frames. However, these posts failed to reach practical reflection level (L2) because the students did not interpret concepts in terms of themselves or apply insights to their future practice as doctors despite being prompted in the online discussion instructions (Appendix D).

The fact that the majority of posts were at L1 level is not surprising for several reasons. First, given that these students were in the fourth month of their five-year professional programme, they may have been inexperienced at reflecting on medicine. This finding supports prior research that indicates that learning to reflect is a demanding skill and requires time and practise to develop (Mann, et al., 2010). In addition, although they were provided with a reflective rubric, students may not have been clear about what reflection entailed.

As in prior research, students in this study at understanding level (L1) (i.e. non-practical reflection) struggled to interpret new theories in relation to their personal experience, and did not articulate how their insights or different worldviews might influence their future practice as doctors (Ziegahn, 2001). It was apparent that some of the study participants may have lacked prior experience with cultures different to their own. This may have hampered students' reflection, because they lacked intercultural experiences upon which to draw from in order to interpret the cultural concepts. Students who lacked prior intercultural experiences may have struggled to connect concepts of culture in medicine to their practice of medicine.

In contrast to prior research findings, students at both 'understanding' (L1) and 'practical reflection' (L2) levels of reflection recognised multiple perspectives (e.g., the doctor's and patient's/family's) and identified how an individual's behaviours was guided by culture (Zieghan, 2001). Focusing students' reflections on the intercultural clinical cases and asking them to identify dimensions of cultures in the actions of the people depicted in the cases may have helped students to attend to more than one perspective.

This study also provides strong evidence that involving students in reflective tasks can help them learn important concepts related to cultural competence in medicine, even if they do not reach reflection level. It was evident that many students at 'understanding' level (L1) sought to gain a personal understanding of the cultural concepts and gained valuable insights about the impact of culture on the doctor-patient relationship. These students identified the importance of recognising how a patient's beliefs will influence their view of the treatment plan, and that doctors and patients may view the treatment differently. They also stressed the importance of being open and responsive to the patient's views in order to build a trusting relationship. These insights display qualities of cultural humility and an

attitude of openness to learning from patients, which are crucial to providing interculturally competent care (Danso, 2016; Fuller, 2003; Gray, 2014).

Students at ‘practical reflection’ level (L2) moved beyond identification and application of a cultural concept (e.g., power distance) and brought their reflection to a personal level, either interpreting the case/concept in relation to themselves or their personal experience or articulating the importance of the concept(s) for their future practice as doctors. This finding reflects Boyd and Fales’ (1983, p.101) definition of reflection as a “process of clarifying and creating ...meaning in terms of self (self in relation to self and self in relation to the world)”.

Students at ‘practical reflection’ level (L2) integrated or applied their insights on the impact of culture in medicine to themselves personally, or to their role as a doctor. Students’ insights included being aware of the limits of their knowledge in intercultural consultations, the importance of seeking help when in doubt, the importance of being open to the patient’s worldview, and the need to negotiate and find common ground in order to overcome differences. These insights support the intercultural competence literature that emphasises the importance of a doctor’s self-awareness in relation to patients’ beliefs (Danso, 2016; Tervalon & Murray-García, 1998). In addition, the students expressed a desire to learn from patients, which is considered crucial for intercultural consultations. Doctors need to be aware of their own perspectives and solicit information in order to understand the patient’s perspective (Danso, 2016; Dogra, 2003; Gray, 2016; Kleinman, 1988).

Although the second most common level of reflection was ‘practical reflection’ (L2), some students engaged in what Ryan (2013) describes as ‘superficial’ reflection. This means that students met the criteria for reflection in that they made reference to their future practice as doctors; however, they did so without discussing why their insight was important for

their future practice, or how a particular insight represented best practice. This finding supports prior research in two ways. First, prior research indicates that some students do not engage in reflection about cultural difference in medicine because they do not perceive the topic as clinically relevant (Hamilton, 2009). Second, similar to prior research, this finding illustrates the challenge of analysing students' written reflection (Wald & Reis, 2010; Wald, et al., 2009). For example, the criteria I used to analyse practical reflection' level (L2) did not sufficiently discriminate 'superficial' reflection from 'practical reflection'.

### **The relationship between students' reflection and their intercultural sensitivity**

Although the majority students at all levels of reflection (L1, L2, and L3) demonstrated ethnorelative perspectives, there was some evidence of qualitative differences in students' reflections, which suggests that some students perceived and analysed the intercultural clinical cases with increasing complexity as their levels of reflection deepened. However, more research is needed to substantiate a direct relationship between students' levels of reflection and their intercultural sensitivity (Bennett, 1986, 1993). The current study found that:

1. Students at the lowest 'understanding' level (L1), recognised one or more perspectives and identified cultural dimensions or underlying conceptual frames in the behaviours of individuals depicted in the intercultural clinical cases. However, these students did not connect their insights to themselves, their prior experience, or their future practice as doctors.
2. Students at 'practical reflection' level (L2) recognised multiple perspectives, applied cultural concepts to people's behaviour, and drew on personal experience to interpret cultural concepts or identified practical applications for their future

practice as doctors. Two students at practical reflection (L2) indicated cultural self-awareness, realising how culture had influenced their worldview and recognising how their worldview differed from others' worldviews.

3. Two students at 'practical reflection' level (L2) engaged in cultural empathy to shift 'frame of reference' or imagine a worldview different from their own. This can also be described as 'perspective taking' and represents the first phase of 'adaptation', the fifth stage in the Intercultural Development Continuum. 'Shifting frame of reference' is a precursor to 'shifting behaviour' in order to interact effectively.
4. One post was at 'critical reflection' level (L3). This post indicated the student was reframing his concept of culture to include not only group membership, but also a way of thinking or construing experience. The post also examined the problematic role of assumptions in intercultural consultations and the importance of being aware of one's own assumptions.

These findings have practical relevance for intercultural or medical educators who wish to facilitate reflection for intercultural competence. These findings indicate that it is crucial for students to interpret concepts of culture in terms of themselves. In order to foster students' capacity to reflect productively on cultural differences in medical contexts, tutors need to foster students insights into a) how their own socialisation or prior experience has influenced the way they perceive a situation; and b) how their insights might inform their future practice as doctors. Facilitating these types of insights in students will help them move beyond 'understanding' a concept to 'reflecting' on a concept or experience, and in this way, support their continued development of intercultural competence. Such cultural self-awareness is a precursor to engaging in cultural empathy in order to try and view a situation from the perspective of another worldview (Bennett, 1993, 2004).

### *Students' ethnocentric versus ethnorelative worldviews*

Two students at L1 level exhibited a 'defensive stance' or 'defence', an ethnocentric perspective. Students who displayed a 'defensive stance' described unfamiliar cultural practices as 'outdated beliefs' or a 'problem' and viewed their own cultural practices as 'common sense' or 'the way to be'. These students appeared unable to suspend judgement in order to try to see the situation from another perspective. The ethnocentric response of these students illustrates how relating to people of other cultures can be challenging for students who lack prior exposure to heterogeneous worldviews (Bennett, 1993; Shaw, Lee, & Williams, 2015). Students with limited experience of other worldviews may view cultural differences in stereotypical ways and resist challenges to their existing norms (Shaw et al., 2015). Simplifying cultural differences and using comparative thinking that assumes one's own culture is superior, and is characteristic of intercultural novices (Bennett, 1986; King & Baxter Magolda, 2005).

The majority of students at all levels of reflection (i.e., L1, L2, and L3), exhibited 'acceptance', an ethnorelative perspective. These students recognised behaviour within the context of the individual's worldview and how the behaviour was underpinned by cultural beliefs or values, and was understandable from a particular cultural context. These students incorporated different viewpoints into their analysis of a case, and contrasted practices in their own culture with unfamiliar practices depicted in the case while withholding judgement. These insights are characteristic of 'acceptance', and also represent intrapersonal characteristics for developing intercultural competence, including creating new categories, recognising more than one perspective, and shifting frames of reference (Bennett, 1993; Deardorff, 2006; Shaw et al., 2015).

Students at the 'acceptance' stage also exhibited an attitude of openness toward cultural differences displayed in the cases. Students articulated the importance of being open to



patients' perspectives and tried to understand the values and beliefs that motivated peoples' behaviour while withholding judgement. This finding suggests that the majority of students in this study were receptive to learning about cultural differences in a medical context. However, it is worth noting that recent research with undergraduate students beginning university suggests that students express an outward appreciation of, and positive attitudes towards, cultural differences, even when their attitudes are not based on substantial experience (Shaw et al., 2015). What this means is that medical students may approach learning about culture in medicine with external openness, but internal detachment, and deeper more apprehensive feelings can remain unexpressed (Shaw et al., 2015).

#### *Social construction of intercultural awareness: sharing prior experience online*

Findings from this study corroborate prior research that indicates that students from non-dominant cultural backgrounds or who had significant overseas experience brought a readiness for intercultural learning (Taylor, 1994; Ziegahn, 2001). There were several examples of students who drew upon personal experience to interpret an intercultural case or shift frame of reference and engage in cultural empathy. Often students began their post by acknowledging their background, such as Bret who talked about differences between his Korean mother and the Korean woman depicted in the case, or the student from a Pacific background who clarified that the concept of 'family' probably included extended family, not just the nuclear family commonly associated with the term 'family'. These students brought socially constructed intercultural awareness with them to the online discussion. The insights they shared, based on their prior experience, provided opportunities for sociocultural learning among peers. This is reminiscent of what Ziegahn (2001) refers to as situated cognition or the learning that occurs between students online. In other words, when students drew on prior experience in their posts they provided

opportunities for sociocultural learning, and they contributed to socially constructed intercultural learning online.

### **Factors that encouraged online reflection**

Another valuable finding from this study is that online discussion can be an effective curricular strategy to encourage intercultural reflection in a medical context; however, tutors must create a 'safe space' online for those students who may be reluctant to reflect publicly. Online discussion is useful for helping students reflect and recognise multiple perspectives or worldviews, which is crucially important for the development of intercultural sensitivity and competence. However, it is important to address students' concerns about the public nature of online reflection. I discuss each of these points in more depth below.

Firstly, in this study, the time lapse, as well as the written and interactive qualities associated with asynchronous online discussion, compelled busy medical students to pause and reflect. Students had the opportunity to read the postings of classmates, and the time to reflect, organise their thoughts, and clarify their understanding before writing a post. Students also had to negotiate meaning when peers expressed new ideas that they had not considered. My study supports and extends prior research that the written and interactive aspects of the asynchronous online discussion encourages reflection in students (Curtis, 2006; Garrison, Anderson, & Archer, 2000; Ziegahn, 2001, 2005).

Secondly, the use of intercultural clinical cases for students to analyse online encouraged reflection in several ways. Similar to prior research, the cases created interest and encouraged students' reflection because they showed how real patients could be affected by cultural misunderstandings between doctor and patient (Roberts, 2007). Next, students were encouraged to reflect when the intercultural clinical cases surprised or perplexed

them. Students wanted to figure out where the breakdowns had occurred between doctor and patient or family and/or think through how to do things differently. Dewey (1933) asserted that students' reflection is triggered by doubt or perplexity, and desire to resolve doubt.

Thirdly, and most importantly, in this study, exposure to peers' multiple perspectives was the chief benefit of the online discussion for students' intercultural learning. Students had different interpretations of the cases. These different interpretations helped students to recognise multiple perspectives and understand that patients may hold different views to them as doctors. In addition, when students drew upon personal experience of other cultures, this provided differing perspectives that supported sociocultural learning. Online discussion with peers can help students integrate new knowledge and apply it to practice situations (Sobral, 2001). This is important because recognising multiple perspectives is considered pivotal to the development of intercultural competence (Shaw et al., 2015). In order to move beyond ethnocentrism, students need to have ongoing reflective engagement with diverse people and ideas (Bennett, 1986; Deardorff, 2006; King & Baxter Magolda, 2005).

### **Factors that hindered online reflection**

It was clear that for some students the online discussion was not a comfortable place in which to reflect. These students appeared to be reluctant to reflect online because of what other students and/or the tutor would think of their post. They indicated they would have felt freer to express themselves in a private space. This raises serious concerns that are also addressed in the literature. When students question the validity of their insights, they may be reluctant to reflect online (Ross, 2011, 2012). Further, if students feel they will be judged by the tutor, they are more likely to reflect in ways that they think the tutor will

approve (Hargreaves, 2004). The reluctance of some students to reflect online emphasises the importance of setting guidelines for respectful discussion in which all students' contributions and experiences are valued in order to create a safe space online for students to reflect (Ziegahn, 2001).

Several aspects of the online assignment also appeared to hinder reflection and intercultural learning. First, the online discussion topic was too similar to topics discussed in the tutorial, so some students felt the ideas had already been discussed. Second, focusing the task on identification and application of concepts in the course materials may have limited the sources that students could draw on to substantiate their ideas. In addition, the task did not encourage students to move beyond identification and application of ideas to analysis and synthesis or deeper reflection. This could have been accomplished by having students focus on a particular issue, consider the practical applications of their learning, or work toward a shared goal (Garrison & Arbaugh, 2007; Jones & Ryan, 2014). Finally, restricting posts to 200 words may have hindered reflection because it limited the scope of what students were able to express (Gilbert & Dabbagh, 2005).

Some students appeared resistant to the requirement to reflect. Some students commented that being required to reflect online lessened the quality of their reflection. Prior research suggests that, while some students actively engage with reflection on cultural competence in medicine, other students do not see its clinical relevance and instead approach it as an obstacle to clear (Hamilton, 2009). This view of the topic could have contributed to some students taking a surface approach to the task (Trigwell & Prosser, 1991), and apparently putting in minimum effort to complete the online task. Students may have taken a surface approach because they did not consider the topic important and preferred to focus on biomedical knowledge (Roberts, 2007).

It is apparent that some tutors were effective in facilitating reflection, while other tutors were not effective. Effective tutors asked questions of specific students and modelled good reflective practice by drawing on past experience and challenged students' assumptions. Tutors' modelling and questioning encouraged their students to engage in reflective behaviours online, question their thinking, and make new realisations. Despite a few excellent examples of effective facilitation of reflection, many tutors did not participate online, and some were ineffective in facilitating reflection. Ineffective comments such as "good job" or "great reflection" did little to encourage deeper reflection in the students and may have misled students into thinking they were reflecting, when they were engaging in 'understanding' (L1). Tutors play a crucial role in moderating and directing the online discussion by posing questions that encourage students to reflect on prior intercultural experiences and societal issues, and reconsider their own views in relation to what others have said (Branch & Paranjape, 2002; Garrison & Cleveland-Innes, 2005; Jones & Ryan, 2014; Ziegahn, 2001). This encourages students to look both inside and outside of themselves (Ziegahn, 2001).

## **Limitations of the study**

Limitations of this study included participants' lack of familiarity with the online discussion technology, recruitment and preparation of participants in the study, and the framework I used to analyse students' levels of reflection. In addition, the use of ethnically-based clinical cases and Hofstede's (1980) dimensions presented some limitations, as did my lens as the researcher. I discuss each of these below.

### **Participants' lack of familiarity with technology**

This study involved implementing an online discussion forum for the first time in the Culture and Health unit. Tutors and students alike lacked familiarity with the technology of

the online discussion function in Moodle, the course management system. Prior to this project, Moodle was primarily used as a repository of information rather than an interactive learning tool. Consequently, the students and tutors were unfamiliar with the mechanics of making posts and engaging in threaded discussions. In fact, over half of the tutors reported that they had never logged onto the course management system prior to this project. To complicate matters further, a new version of Moodle was launched in 2012, the year of the study. Despite my efforts to provide guidelines and practice for tutors and students in using the online discussion forum, participants lack of familiarity with the technology may have limited both the quantity and quality of their online posts. Students' lack of familiarity with how threaded discussions work may have contributed to the predominance of serial monologues rather than a sequence of posts focused on a similar topic (e.g., a case or cultural dimension).

## **Recruitment and preparation of participants**

A further limitation of this study involved the recruitment and preparation of participants. Firstly, the manner in which tutors were recruited and trained in the use of the online discussion forum may have contributed to lack of participation. As described in Chapter Four, a sample of 12 tutorials were selected from a total of 23 that met the criteria for selection. Of the twelve tutorial groups chosen for the sample, only half of the tutors attended the briefing prior to commencement of data collection. This means that the lead tutor, rather than the researcher, recruited and explained the objectives of the study to half of the tutors who participated. In addition, these tutors oriented themselves to the online forum with the aid of written materials, rather than the face-to-face instruction provided in the tutor briefing. Participation in the online forum may have been more challenging for those tutors who did not attend the briefing, and this may have contributed to their lack of participation.

Another limitation involved the recruitment of the students. As explained in Chapter Four, because of the large number of tutorials, it was impossible for me to personally invite all of the student participants. Therefore, if a tutor decided to participate in the study, they were asked to recruit student participants in their tutorial group. Students may have felt compelled to participate when asked by their tutor, despite the fact that the written information stressed that their participation was entirely voluntary. Consequently, half the tutors and all the students were asked to participate in the study by a third party rather than by me as researcher. Although tutors and students alike were assured that participation was voluntary, it is possible participants may have felt obliged to participate, which could impact the credibility of the findings.

### **Methods of analysing students' reflection**

There were three limitations related to my methods of analysing students' levels of reflection. Firstly, although I sought the advice of colleagues in developing my reflective framework, and I discussed my analysis with my supervisors, I was solely responsible for analysing students' levels of reflection. Having more than one researcher to analyse students' reflection and establishing inter-rater reliability could have increased the credibility of the findings in this study. Secondly, my understanding of reflection grew and changed over the course of the study. If I were to code the same posts today, I would likely code them differently which would influence the findings. As mentioned in Chapter Four, I make no claim of transferability, but instead I have tried to provide enough detail about the context and process of the research for the reader to determine if these findings might be applicable to other contexts (Robson, 1993).

The third limitation, in relation to my analysis of students' levels of reflection, was the reflective framework used. In the process of analysing students' levels of reflection and in

examining the findings, I discovered that the reflective framework was not fine-grained enough to discriminate between practical reflection and what Ryan (2013) refers to as ‘superficial’ practical reflection. Students met the criteria for practical reflection (L2) if they mentioned a practical application for their medical practice. However, some students made only general statements without providing more in-depth analysis that included why their insights were important, or how their insights represented best practice in culturally competent care. Some students who were coded L2 may only have engaged in superficial practical reflection rather than ‘practical reflection’, but the framework did not discriminate between the two.

### **Use of ethnicity-based cases and Hofstede’s dimensions**

Having students use Hofstede’s (1980) dimensions to analyse clinical cases involving people of different ethnicities could have encouraged stereotyping or essentialist views of culture. The use of ethnically-based cases could have incorrectly led students to think that national background or ethnicity determines worldview (Williamson, 2002), or that culture is something that is static and unchanging (Reeder, Macfayden, Roche, & Chase, 2004). In the few years following this study, two Korean students have objected to the case involving the Korean wife who was reluctant to make end-of-life decisions for her husband. Both of these students felt the case reinforced inaccurate stereotypes of Korean culture.

In addition, the use of clinical cases that focused on ethnic groups could have reinforced an inaccurate assumption that most doctors are white, and that barriers to care arise only with patients who are ethnically different from the doctor (Dharamsi, 2011). Conversely, the use of ethnically-based cases may have unconsciously implied that white physicians are a homogenous group, and thus failed to acknowledge the diversity of worldviews among



physicians based on gender, social class, and economic status, and the like (Dharamsi, 2011).

### **The researcher's lens**

As mentioned in Chapter One, I brought an international educator's lens rather than a clinician's lens to my analysis of students' online reflections about intercultural consultations. While I have extensive experience interacting with people from diverse cultural backgrounds, my interactions have been in an education setting rather than a clinical setting. I undoubtedly lack insights into medical practice that a clinician would have. Consequently, my background could have limited my ability to analyse students' reflection about clinical best practice related to medical consultations, and their ability to apply best practice to an intercultural context. Having a clinical background would have influenced the analysis of students' online posts and thus could have resulted in different findings.

## **Implications for facilitating reflection for intercultural learning in medicine**

### **Implications for task design**

The findings from this study point to the importance of task design in order to encourage reflection. To begin, tasks must be sufficiently different from in-class discussions to engage students' interest. In addition, course designers should be cautious about imposing a low word limit. Limiting word count can limit students' reflection, because students may not have the scope to develop their ideas and move to deeper levels of reflection (Arnold & Ducate, 2006).

Fostering practical reflection through more sustained, in-depth discussion online requires tasks that challenge and effectively engage students. To increase engagement, students could be asked to complete authentic tasks such as community placements or ethnographic interviews, alongside individual reflection and group work with peers online. Alternatively, students could be given problem-based scenarios involving controversial issues that raise ethical issues, such as treating clients who have undergone female genital circumcision. Issue-based discussions result in deeper reflection because they provide more opportunity for students to make the connection between theory and practice (Jones & Ryan, 2014). Students could then be asked to work collaboratively online in small groups of 4-5, to arrive at a solution or course of action in their case and present their solution to classmates in the tutorial (Murphy, 2004). When students are required to work towards a shared goal, their discussions are more substantive because they must come to an agreed upon resolution (Garrison & Arbaugh, 2007). Considering others' ideas and reconciling them with one's own perspective would encourage deeper reflection. In addition, asking students to articulate the practical application of their learning, and how or why it represents best practice in medicine, would encourage students to refer to sources in the literature and bring their conclusions back to themselves as clinicians (Ryan, 2013). In doing so, students would be encouraged to move beyond 'superficial' reflection to reach 'practical reflection' (L2) and beyond.

### **Implications for teaching and facilitating intercultural reflection**

In order to teach and facilitate reflection, tutors and students alike need a clear understanding of what constitutes reflection, and students need to know how reflective capacity is related to the unit objectives and to professional practice (Aronson, 2011; Boud & Walker, 1998). In addition, tutors need to be able to recognise different levels of

reflection in students and then, through skilful questioning at each level, move students to deeper levels of reflection (Ryan, 2013).

Tutors should also challenge students' assumptions and pose meaningful questions that encourage students to explore past experience and societal issues in relation to culture in a medical context (Swan et al., 2008; Ziegahn, 2001). In addition, tutors can foster an environment in which students feel safe to reflect by maintaining a reciprocal, less hierarchical relationship and share about their own experiences as a way to model reflection (Bearman & Molloy, 2017; Jones & Ryan, 2014). Importantly, they should prompt students to think about their prior socialisation and how that has affected the way they perceive an intercultural encounter and think through the implications of their insights for their future practice as doctors. In order to effectively promote intercultural learning and reflection, tutors should direct their questions and prompts at individual students rather than the group (Means, Toyama, Murphy, Bakia, & Jones, 2009). This may encourage students to participate and share their unique viewpoints.

Due to time constraints, it may be impractical for tutors to comment on each post; however, by moderating the discussion and providing periodic feedback and commentary on students' reflections, the tutors can provide examples of reflection and help students take control of their learning (Garrison, 2003; Garrison & Cleveland-Innes, 2005).

Alternatively, tutors could teach students how to facilitate reflection in their peers, and then gradually withdraw from the online discussions and allow students to facilitate reflection in one another (Guldborg & Pilkington, 2007).

In order to encourage critical reflection about the impact of culture in medicine, course content needs to focus more broadly on social determinants of health, such as the impact of unemployment, lack of education, or disparity in access to healthcare. Any exploration of the social determinants of health should include understanding how the culture of

medicine and health delivery organisations replicate and foster social inequities present in society at large (Kuper et al., 2017). Students need challenging cases that provide opportunities to think critically about sociocultural factors that influence the patient and doctor within the wider societal context. For example, students could discuss prior research or narratives that describe patients' experiences in the healthcare system, or students could volunteer in underserved communities (e.g., refugees or children living in poverty) and reflect on their experiences and worldview vis a vis their clients.

To encourage critical reflection, students need to examine their own assumptions, values, and implicit and explicit biases and the power relationships associated with their worldview (Kuper et al., 2017; Ziegahn, 2005). A safe environment and skilled facilitator are necessary to encourage students' critical reflection on the role of biases and positions of power associated with their worldviews, as well as how social determinants of health and medical culture perpetuate health inequities. We cannot assume that all tutors will be able or willing to facilitate students' critical reflection about power and privilege associated with students' worldviews, or about social determinants of health. Prior research indicates that students' uncertainty around discussing cultural diversity in medicine can lead them to prefer fact-base discussion rather than engagement in reflection (Dogra, Giordano, & France, 2007).

Careful preparation of tutors is necessary in order for them to facilitate deeper, more critical reflection in students. Tutors need to have a good grasp of critical reflection and experience examining their own values, biases, and assumptions. It is crucial that the tutor fosters an environment in which students feel safe to make mistakes without fear of embarrassment, and can explore unfamiliar perspectives and investigate unusual hypotheses (Mintz, 2009; Ross, 2011). Consequently, successfully facilitating discussions that involve reflection on students' own values, assumptions, and biases, as well as the wider societal and institutional context, requires sensitivity and skill on the part of tutors

involved in leading such discussions (Morell, Sharp, & Crandall, 2002). Again, clear ground rules that encourage respectful dialogue in which all experiences are valued are crucial. It is simplistic to assume that tutors (who have varying knowledge, skills, and sensitivity) can necessarily facilitate students' critical reflection on their biases and assumptions and how, when translated into practice, these might perpetuate health inequities.

The structure of teaching in Early Learning in Medicine at the University of Otago may preclude teaching about culture in medicine in critically reflective ways. The integrated modules are taught by up to 28 different tutors. These tutors will undoubtedly have differing views on the value of the topic and possess different skills and abilities in facilitating students' critical reflection about culture in medicine, especially within the wider social context.

### **Implications for facilitating online intercultural reflection**

Despite the apparent benefits of the online discussions for students' reflection and intercultural learning discussed earlier in this chapter, there are important challenges to consider when implementing an online teaching and learning component alongside face-to-face tutorials. Firstly, monitoring and facilitating reflective discussions, and fostering a trusting learning environment online, require significant time and human resources (Gray & Tobin, 2010). Tutors and students need sufficient time to practise and become familiar with the online discussion technology for it to be effective (Ertmer, Ottenbreit-Leftwich, Sadik, Sendurur, & Sendurur, 2012). Secondly, tutors need to establish ground rules for respectful discussion online so that students feel safe to reflect in a public space (Aronson, 2011; Ziegahn, 2001). It is also important that tutors acknowledge that reflecting in a public space online can be challenging for some students and explain the benefits of online reflection for students' learning, such as exposure to multiple perspectives.

Thirdly, it is crucial to get buy-in from tutors about the value of the online discussion for students' learning by providing research findings on its value in medical education. The tutor's beliefs about the value of the online discussion for his/her students' learning will influence student attitudes (Blakey, 2016; Gray & Tobin, 2010). Finally, programme leaders need to recognise that monitoring and facilitating students' online discussions is time consuming and demanding. Tutors need to be compensated for their time, otherwise they are unlikely to engage in the online discussions.

It is worth noting that some recommendations from this study were implemented in subsequent years in the Culture, Self and Diversity unit (formerly Culture and Health Unit). For example, in the year following this study the Orr et al. (1995) article was not discussed in the first tutorial prior to the online discussion to eliminate the issue of redundancy in the online task. In 2015, the definition of reflection was clarified for tutors and students. In 2018, students have done a reflective exercise in the first tutorial of the year to establish a baseline understanding of reflection. The tutors also experienced the same exercise at their tutor training prior to the start of the semester. The exercise experienced by both tutors and students establishes a shared understanding of what constitutes reflection. Tutors have also received specific guidance on effective means for providing feedback to encourage reflection in their students. Different types of reflective writing tasks are assigned throughout the year to reinforce the concept of reflection and develop students' reflective skills over a longer period of time. The online discussion was eliminated after several years due to lack of tutor buy-in. However, following a research symposium in 2017 where results of the study were shared, the course coordinator and lead tutor are considering reintroduction of the online discussions in 2019.

## Future research directions

To better understand the development of medical students' reflective capacity early in their training, future research could examine students' online reflection over a year-long module. Reflection could be introduced as a core component of the course, with the stated objective of providing multiple means for developing students' reflective thinking, such as guided written reflection via templates, online discussions, and summative reflective essays. A longitudinal approach could provide numerous opportunities for giving students formative feedback on their reflective thinking throughout the year. Analysis could provide insights into the development of second-year students' reflective ability and the role of formative feedback from tutors and peers on students' reflection. Tutors' ability to provide feedback on their students' reflection could also be analysed. Findings would provide insights into what topics and reflective activities were most effective in fostering a deeper level of students' reflection. It would also be instructive to see if students developed an appreciation for the role of reflection in their medical training over time.

Future research could also combine the use of online reflection and discussion with clinical placements to explore the impact of culture in medicine. Students in clinical placements could be asked to keep a reflective journal and periodically engage in small group discussions online about critical incidents that occur on placement. Tutors could use reflective prompts from this research, and a framework for intercultural competence, to help students think through aspects of the incidents and their responses (see for example Seeleman, Suurmond, & Stronks, 2009). Students' online discussions and journals could be analysed for levels of reflection and development of intercultural competence.

## Conclusion

In this study, I explored how participation in online discussions influenced second-year medical students' reflections on culture in medicine. The aim of the study was to examine the role of reflection in the development of students' intercultural sensitivity, a component of intercultural competence. Specifically, I sought to answer the following questions:

- What levels of reflection do students exhibit in their online posts about intercultural interactions in a medical context?
- What is the relationship between students' levels of reflection and their intercultural sensitivity—that is, noticing and analysing cultural differences and identifying appropriate strategies for effective interaction.
- What are the factors that contribute to or hinder students' online reflection and intercultural learning?

This study provides evidence that engaging medical students early in their professional programme in reflection about the impact of culture in medicine is challenging; however, it is a worthwhile activity that can increase students' understanding of intercultural competence in healthcare. The majority of students in this study were at 'understanding' (L1) or non-practical reflection level, and only one post was a 'critical reflection' level (L3).

Students at 'understanding' level recognised one or more perspective and identified cultural dimensions in the behaviour of individuals depicted in intercultural clinical cases. However, they did not interpret cultural concepts in terms of themselves or their prior experience or apply insights to their future practice as doctors. Nevertheless, many students at 'understanding' level endeavoured to gain a personal understanding of the cultural dimensions that underpinned people's actions and made valuable insights into the



impact of culture in medicine despite not reaching 'practical reflection' level (L2). Students' insights included recognising that patients' beliefs will influence their view of the treatment plan, that doctors may view the treatment differently to the patient, and that it is important to be open and responsive to patients' views in order to build trust.

The study provides some evidence regarding the relationship between students' levels of reflection and their intercultural sensitivity, an aspect of intercultural competence. While a few students at L1 demonstrated a 'defensive stance', an ethnocentric perspective (S2a), the majority of students at L1, L2 and L3 displayed 'acceptance' (S4), an ethnorelative perspective. However, there were qualitative differences in the ways students perceived and analysed the intercultural clinical cases at L1 and L2. Students at L1 who exhibited 'acceptance' suspended judgement and recognized a person's action made sense within their cultural context or worldview. Students at L2 not only recognised multiple perspectives and applied cultural concepts to people's behaviours, but they also drew on personal experience to interpret the cultural context of an individual, interpreted insights in terms of themselves and/or applied insights to their future practice as doctors. A few students at 'practical reflection' level (L2) demonstrated cultural self-awareness by articulating how culture had influenced their worldview and recognising how their worldview differed from others' worldviews. Two students at 'practical reflection' level engaged in cultural empathy to 'shift their frame of reference' and imagine a worldview different to their own, which is indicative of the first phase of 'adaptation' (S5a). The one post at 'critical reflection' (L3) level indicated the student was aware of the problematic role of assumptions in intercultural consultations, and the importance of taking time to ensure understanding. He also indicated he was reframing his conception of culture to include peoples' ways of thinking. Further research is needed to corroborate the

relationship between students' levels of reflection and their intercultural sensitivity, or the ability to construe experiences in more complex ways (Bennett's, 1986, 1993).

In addition, the study findings support and extend prior research that found that students from non-dominant cultural background or with significant overseas experience come with sensitivity to cultural differences (Taylor, 1994; Ziegahn, 2001). In this study, when peers drew on personal experience to interpret the intercultural clinical cases, they provided opportunities for sociocultural learning among peers. Students often described their positionality or background in their post and provided an opportunity for sociocultural learning among peers.

These findings are important for intercultural or medical educators who wish to facilitate reflection for intercultural learning. This research indicates the importance of students interpreting concepts of culture in terms of themselves—that is, understanding how prior socialisation or prior experience had influenced the way they perceived an intercultural encounter, and how their insights might inform their future practice. Facilitating students' movement from 'understanding' to 'practical reflection' level involves bringing insights about culture in medicine back to a personal level in relation to the self, past experience or future practice. Developing students' cultural self-awareness in this way is a precursor to students 'shifting their frame of reference' or viewing a situation from another perspective or worldview.

The study also contributes to online learning in the health professions literature, highlighting the advantages and disadvantages of online discussion for medical students' reflection and intercultural learning. The findings indicated that online discussions can be an effective strategy to engage busy medical students in reflection about culture in medicine; however, not all students enjoy reflecting in a public space. Similar to prior research, the additional time, and the written and interactive aspects of the asynchronous

online discussion encouraged reflection in students. Students had time to read the comments of peers, and to clarify and organise their own thoughts before writing a post. Moreover, students' different interpretations of the intercultural clinical cases exposed peers to multiple perspectives. The students' feedback consistently stressed that exposure to multiple perspectives was the major advantage of the online discussions. This is important because recognising that multiple perspectives exist is pivotal for beginning to develop intercultural competence. Recognising multiple perspectives is also important for developing the skills to work on interprofessional teams (Bennett, 1986, 1993; Deardorff, 2006 (Barr, 2013; Bennett, 1986, 1993; Deardorff, 2006).

A disadvantage of the online discussion was the public nature of online reflection. Some students said they would have felt freer to express themselves in a private reflection. Students may be reluctant to reflect online if they are unsure of the validity of their insights (Ross, 2011, 2012), or if they are worried about the tutor's approval (Hargreaves, 2004). Students' reluctance to reflect online makes clear the importance of ground rules for respectful discussion in order to create a safe space in which students can reflect. It also emphasises the need to clarify to students the value of online discussion for their learning and reflection, and its importance to the goals of the unit.

In conclusion, this study highlighted the value of online discussion as a possible tool for fostering recognition of multiple perspectives and the development of intercultural competence in medical students. It also highlighted the complexity of fostering students' reflection online, and the important work of tutors in stimulating students to reflect more deeply by understanding how prior experience and socialisation influence the way they interpret intercultural consultations.



# REFERENCES

- Abell, M. L., Manuel, J., & Schoeneman, A. (2015). Student Attitudes Toward Religious Diversity and Implications for Multicultural Competence. *Journal of Religion & Spirituality in Social Work: Social Thought*, 34(1), 91–104.  
<https://doi.org/10.1080/15426432.2014.943920>
- Akyol, Z., & Garrison, D. R. (2011). Understanding cognitive presence in an online and blended community of inquiry: Assessing outcomes and processes for deep approaches to learning. *British Journal of Educational Technology*, 42(2), 233–250.  
<https://doi.org/10.1111/j.1467-8535.2009.01029.x>
- Akyol, Z., & Garrison, D. R. (2014). The development of a community of inquiry over time in an online course: Understanding the progression and integration of social, cognitive and teaching presence. *Journal of Asynchronous Learning Networks* 12, 3-22.
- Alcoff, L. (1988). Cultural feminism versus post-structuralism: The identity crisis in feminist theory. *Signs: Journal of women in culture and society* 13(3), 405-436
- Anand, R., & Lahiri, I. (2009). Developing Skills for Interculturally Competent Care. In D. K. Deardorff (Ed.), *The Sage handbook of intercultural competence* (pp. 387–402). Thousand Oaks, Calif: Sage Publications.
- Andresen, M. A. (2009). Asynchronous discussion forums: Success factors, outcomes, assessments, and limitations. *Educational Technology & Society*, 12(1), 249–257.
- Andrusyszyn, M.-A., & Davie, L. (1997). Facilitating Reflection through Interactive Journal Writing in an Online Graduate Course: A Qualitative Study. *Journal of Distance Education*, 12(1–2), 103–126.
- Ang, S., & Dyne, L. V. (2015). *Handbook of Cultural Intelligence*. Routledge.

- Arnold, N., & Ducate, L. (2006). Future foreign language teachers' social and cognitive collaboration in an online environment. *Language Learning and Technology*, 10(1), 42–66.
- Aronson, L. (2011). Twelve tips for teaching reflection at all levels of medical education. *Medical Teacher*, 2011, Vol.33(3), p.200-205, 33(3), 200–205.  
<https://doi.org/10.3109/0142159X.2010.507714>
- Ash, S. L., & Clayton, P. H. (2009). Generating, deepening, and documenting learning: The power of critical reflection in applied learning. *Journal of Applied Learning in Higher Education*, 1(1), 25–48.
- Australian Medical Council Ltd. (2012). Australian Medical Council Accreditation Standards: Attributes of Graduates. Retrieved from  
<http://www.amc.org.au/index.php/ar/bme/standards>
- Bacal, K., Jansen, P., & Smith, K. (2006). Developing cultural competency in accordance with the Health Practitioners Competence Assurance Act. *New Zealand Family Physician*, 33(5), 305–309.
- Bain, J. D., Ballantyne, R., Mills, C., & Lester, N. C. (2002). *Reflecting on Practice: Student Teachers' Perspectives*. Flaxton, Qld: Post Pressed. Retrieved from  
<http://espace.library.uq.edu.au/view/UQ:172324>
- Bain, J. D., Ballantyne, R., Packer, J., & Mills, C. (1999). Using Journal Writing to Enhance Student Teachers' Reflectivity During Field Experience Placements. *Teachers and Teaching*, 5(1), 51–73. <https://doi.org/10.1080/1354060990050104>
- Bali, M. (2014). Why doesn't this feel empowering? The challenges of web-based intercultural dialogue. *Teaching in Higher Education*, 19(2), 208–215.  
<https://doi.org/10.1080/13562517.2014.867620>
- Barr, H. (2013). Toward a theoretical framework for interprofessional education. *Journal of Interprofessional Care*, 27(1), 4–9. <https://doi.org/10.3109/13561820.2012.698328>

- Baxter, J. (2002). Barriers to health care for Maori with known diabetes: A literature review and summary of the issues. Te Ropu Rangahau Hauora a Ngai Tahu, University of Otago.
- Beagan, B. L., & Kumas-Tan, Z. (2009). Approaches to diversity in family medicine “I have always tried to be colour blind.” *Canadian Family Physician*, 55(8), e21–e28.
- Bearman, M., & Molloy, E. (2017). Intellectual streaking: The value of teachers exposing minds (and hearts). *Medical Teacher*, 39(12), 1284–1285.  
<https://doi.org/10.1080/0142159X.2017.1308475>
- Bell, A., Kelton, J., McDonagh, N., Mladenovic, R., & Morrison, K. (2011). A critical evaluation of the usefulness of a coding scheme to categorise levels of reflective thinking. *Assessment & Evaluation in Higher Education*, 36(7), 797–815.  
<https://doi.org/10.1080/02602938.2010.488795>
- Bender, T. (2012). *Discussion-Based Online Teaching To Enhance Student Learning: Theory, Practice and Assessment*. Stylus Publishing, LLC.
- Bennett. (2012). Paradigmatic Assumptions and a Developmental Approach to Intercultural Learning. In M. V. Berg, R. M. Paige, & M. J. Bennett (Eds.), *Student Learning Abroad: What Our Students Are Learning, What They're Not, and What We Can Do About It*. Sterling, VA: Stylus Publishing, LLC.
- Bennett, J. (2009). Cultivating Intercultural Competence: A Process Perspective. In *The SAGE Handbook of Intercultural Competence* (pp. 121–140). Thousand Oaks, CA & London: SAGE Publications.
- Bennett, J., & Bennett, M. (2003). Developing Intercultural Sensitivity: An Integrative Approach to Global and Domestic Diversity. In D. Landis, J. Bennett, & M. J. Bennett (Eds.), *Handbook of Intercultural Training* (Third, pp. 147–165). Thousand Oaks, CA & London: SAGE Publications.

- Bennett, M., & Castiglioni, I. (2004). Embodied Ethnocentrism and the Feeling of Culture. In D. Landis, J. Bennett, & M. J. Bennett (Eds.), *Handbook of Intercultural Training* (pp. 249–265). Thousand Oaks, CA: SAGE Publications.
- Bennett, M. J. (1986). A developmental approach to training for intercultural sensitivity. *International Journal of Intercultural Relations*, 10(2), 179–196.  
[https://doi.org/10.1016/0147-1767\(86\)90005-2](https://doi.org/10.1016/0147-1767(86)90005-2)
- Bennett, M. J. (1993). Towards Ethnorelativism: A Developmental Model of Intercultural Sensitivity. In M. R. Paige (Ed.), *Education for the Intercultural Experience* (pp. 21–71). Yarmouth, ME: Intercultural Press.
- Bennett, M. J. (1998). Overcoming the Golden Rule: Sympathy and Empathy. In D. Nimmo (Ed.), *Basic Concepts of Intercultural Communication: Selected Readings*. (pp. 191–214). Yarmouth, ME: Intercultural Press, Inc. Retrieved from <http://eric.ed.gov.ezproxy.otago.ac.nz/?id=ED452575>
- Bennett, M. J. (2004). Becoming interculturally competent. In J. S. Wurzel (Ed.), *Toward Multiculturalism: A Reader in Multicultural Education*. Newton, MA: Intercultural Resource Corporation.
- Bennett, M. J. (2009). Defining, measuring, and facilitating intercultural learning: a conceptual introduction to the Intercultural Education double supplement. *Intercultural Education*, 20(sup1), S1–S13.  
<https://doi.org/10.1080/14675980903370763>
- Bennett, M. J. (2013). *The Ravages of Reification: Considering the Iceberg and Cultural Intelligence, Towards De-reifying Intercultural Competence*. Keynote Presentation presented at the Forum on Intercultural Learning and Exchange (FILE) IV, Colle Val d'Elsa, Italy. Retrieved from <http://www.fondazioneintercultura.org/en/Conferences/Forum-on-intercultural-learning-and-exchange/>



- Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Penguin UK.
- Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology*, 46(1), 5–34. <https://doi.org/10.1111/j.1464-0597.1997.tb01087.x>
- Betancourt, J. R. (2006). Cultural competence and medical education: many names, many perspectives, one goal. *Academic Medicine: Journal of the Association of American Medical Colleges*, 81(6), 499–501. <https://doi.org/10.1097/01.ACM.0000225211.77088.cb>
- Betancourt, J. R., & Green, A. R. (2010). Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. *Academic Medicine*, 85(4), 583–584. <https://doi.org/10.1097/ACM.0b013e3181d2b2f3>
- Betancourt, J. R., Green, A. R., Carillo, J. E., & Ananeh-Firempong, O. (2003). Defining Cultural Competence: a practical framework for addressing racial/ethnic disparities. *Public Health Reports*, 118(4), 293–302.
- Biggs, J., Kember, D., & Leung, D. Y. P. (2001). The revised two-factor Study Process Questionnaire: R-SPQ-2F. *British Journal of Educational Psychology*, 71(1), 133. <https://doi.org/10.1348/000709901158433>
- Bird, A., Mendenhall, M., Stevens, M. J., & Oddou, G. (2010). Defining the content domain of intercultural competence for global leaders | Journal of Managerial Psychology | Vol 25, No 8. *Journal of Managerial Psychology*, 25(8), 810–828. <https://doi.org/10.1108/02683941011089107>
- Black, P. E., & Plowright, D. (2010). A multi- dimensional model of reflective learning for professional development. *Reflective Practice*, 11(2), 245–258. <https://doi.org/10.1080/14623941003665810>
- Black, R. W. (2008). *Adolescents and Online Fan Fiction*. New York; Washington DC: Peter Lang.

- Blakey, A. J. (2016). *Cultivating student thinking and values in medical education: What teachers do, how they do it and who they are*. University of Otago. Retrieved from <https://ourarchive.otago.ac.nz/handle/10523/6496>
- Blasco, M. (2012). On reflection: is reflexivity necessarily beneficial in intercultural education? 1. *Intercultural Education*, 23(6), 475–489. <https://doi.org/10.1080/14675986.2012.736750>
- Boeije, H. (2002). A Purposeful Approach to the Constant Comparative Method in the Analysis of Qualitative Interviews. *Quality and Quantity*, 36(4), 391–409. <https://doi.org/10.1023/A:1020909529486>
- Boenink, A. D., Oderwald, A.K., De Jonge, P., Van Tilburg, W., & Smal, J.A. (2004). Assessing student reflection in medical practice. The development of an observer-rated instrument: reliability, validity and initial experiences. *Medical Education*, 38(4), 368-377. <https://doi.org/10.1046/j.1365-2923.2004.01787.x>
- Bolam, B., Gleeson, K., & Murphy, S. (2003). “Lay Person” or “Health Expert”? Exploring Theoretical and Practical Aspects of Reflexivity in Qualitative Health Research. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 4(2). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/699>
- Boud, D. (2001). Using journal writing to enhance reflective practice. *New Directions for Adult and Continuing Education*, 2001(90), 9–18. <https://doi.org/10.1002/ace.16>
- Boud, D. (2010). Relocating reflection in the context of practice. In H. Bradbury, N. Frost, S. Kilminster, & M. Zukas (Eds.), *Beyond Reflective Practice: New Approaches to Professional Lifelong Learning* (pp. 25–35). London; New York: Routledge.
- Boud, D., Keogh, R., & Walker, D. (1985). *Reflection, turning experience into learning*. New York: Kogan Page.

- Boud, D., & Walker, D. (1998). Promoting reflection in professional courses: the challenge of context. *Studies in Higher Education*, 23(2), 191–206.  
<https://doi.org/10.1080/03075079812331380384>
- Boutin-Foster, C., Foster, J. C., & Konopasek, L. (2008). Viewpoint: physician, know thyself: the professional culture of medicine as a framework for teaching cultural competence. *Academic Medicine: Journal of the Association of American Medical Colleges*, 83(1), 106–111. <https://doi.org/10.1097/ACM.0b013e31815c6753>
- Boyd, E. M., & Fales, A. W. (1983). Reflective Learning Key to Learning from Experience. *Journal of Humanistic Psychology*, 23(2), 99–117.  
<https://doi.org/10.1177/0022167883232011>
- Branch, W. T. J., & Paranjape, A. (2002). Feedback and Reflection: Teaching Methods for Clinical Settings. *Academic Medicine December 2002*, 1185–1188.
- Brewer, M. B., & Campbell, D. T. (1976). *Ethnocentrism and intergroup attitudes: East African evidence*. Oxford, England: Sage.
- Brockbank, M, & McGill, I. (2007). Requirements for Reflection. In *Facilitating reflective learning in higher education* (2nd ed., pp. 64–84). Columbus, OH: McGraw Hill; Maidenhead, England; New York.
- Brookfield, S. (1994). Tales from the dark side: a phenomenography of adult critical reflection. *International Journal of Lifelong Education*, 13(3), 203–216.  
<https://doi.org/10.1080/0260137940130303>
- Brookfield, S. (1995). *Becoming a critically reflective teacher*. San Francisco: Jossey-Bass.
- Brookfield, S. (1998). Critically Reflective Practice. *Journal of Continuing Education in the Health Professions*, 18(4), 197–205. <https://doi.org/10.1002/chp.1340180402>
- Brookfield, S. (2000). Transformative Learning as Ideology Critique. In J. Mezirow (Ed.), *Learning as transformation: critical perspectives on a theory in progress* (pp. 125–150). San Francisco: Jossey-Bass

- Brookfield, S. (2009). The concept of critical reflection: promises and contradictions. *European Journal of Social Work*, 12(3), 293–304.  
<https://doi.org/10.1080/13691450902945215>
- Brookfield, S. (2017). *Becoming a Critically Reflective Teacher*. John Wiley & Sons.
- Byram, M. (1997). *Teaching and Assessing Intercultural Communicative Competence*. Clevedon England; Philadelphia: Multilingual Matters.
- Byram, M. B., Talkington, B., & Lengel, L. (2007). *Setting the context, highlighting the importance: Reflections on interculturality and pedagogy*. Retrieved from  
<https://www.llas.ac.uk/resources/paper/2048>
- Campbell, D. T., & LeVine, R. A. (1968). Ethnocentrism and intergroup relations. In *Theories of cognitive consistency: a sourcebook*. Rand-McNally: Chicago.
- Campinha-Bacote, J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing*, 13(3), 181–184. <https://doi.org/10.1177/10459602013003003>
- Canales, M. K., & Bowers, B. J. (2001). Expanding conceptualizations of culturally competent care. *Journal of Advanced Nursing*, 36(1), 102–111.
- Cantillon, P., & Sargeant, J. (2008). Giving feedback. *BMJ*, 337, a1961.  
<https://doi.org/doi:10.1136/bmj.a1961>
- Chen, G.-M., & Starosta, W. (2000). The Development and Validation of the Intercultural Sensitivity Scale. *Communication Studies Faculty Publications*. Retrieved from  
[http://digitalcommons.uri.edu/com\\_facpubs/36](http://digitalcommons.uri.edu/com_facpubs/36)
- Clark, P. G. (2009). Reflecting on reflection in interprofessional education: Implications for theory and practice. *Journal of Interprofessional Care*, 23(3), 213–223.  
<https://doi.org/10.1080/13561820902877195>

- Clegg, S. (1999). Professional education, reflective practice and feminism. *International Journal of Inclusive Education*, 3(2), 167–179.  
<https://doi.org/10.1080/136031199285101>
- Clift, R. T., Houston, W. R., & Pugach, M. C. (1990). *Encouraging reflective practice in education: an analysis of issues and programs*. New York: Teachers College Press, Teachers College, Columbia University.
- Collins, J. C., & Rocco, T. S. (2014). Disparities in Healthcare for Racial, Ethnic, and Sexual Minorities. *New Directions for Adult and Continuing Education*, 2014(142), 5–14.  
<https://doi.org/10.1002/ace.20090>
- Cooke, M., Irby, D. M., & O'Brien, B. C. (2010). Being a Doctor: Foundations of Professional Education. In *Educating physicians: a call for reform of medical school and residency* (pp. 34–74). San Francisco, CA: Jossey-Bass.
- Crandall, S. J., George, G., Marion, G. S., & Davis, S. (2003). Applying theory to the design of cultural competency training for medical students: a case study. *Academic Medicine : Journal of the Association of American Medical Colleges*, 78(6), 588–594.  
<https://doi.org/10.1097/00001888-200306000-00007>
- Crengle, S. (2000). The development of Māori primary services. *Pacific Health Dialog*, 7(1), 48–53.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative research. *Theory into Practice*, 39(3), 124–130.
- Curtis, J. N. (2006). Using Online Discussion Forums to Promote Critical Reflection among Pre and In-Service HIV/AIDS Educators and Service Providers. *International Electronic Journal of Health Education*, 9, 166–179.
- Danso, R. (2016). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*.  
<https://doi.org/10.1177/1468017316654341>

- Deardorff, D. K. (2006). Identification and Assessment of Intercultural Competence as a Student Outcome of Internationalization. *Journal of Studies in International Education*, 10(3), 241–266. <https://doi.org/10.1177/1028315306287002>
- Deardorff, D. K. (2011). Assessing intercultural competence. *New Directions for Institutional Research*, 2011(149), 65–79. <https://doi.org/10.1002/ir.381>
- DeSantis, L. (1994). Making anthropology clinically relevant to nursing care. *Journal of Advanced Nursing*, 20(4), 707–715. <https://doi.org/10.1046/j.1365-2648.1994.20040707.x>
- DeSouza, R. (2008). Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing*, 13(2), 125–135. <https://doi.org/10.1177/1744987108088637>
- Dewey, J. (1933). How we think: A restatement of the relation of reflective thinking to the educational process. *Lexington, MA: Heath*.
- Dewey, J. (1944). *Democracy and Education*. Courier Dover Publications.
- Dharamsi, S. (2011). Moving beyond the limits of cultural competency training. *Medical Education*, 45(8), 764–766. <https://doi.org/10.1111/j.1365-2923.2011.04044.x>
- DiMauro, V., & Gal, S. (1994). Use of Telecommunications for Reflective Discourse of Science Teacher Leaders. *Journal of Science Education and Technology*, 3(2), 123–135.
- Dogra, N. (2003). Cultural competence or cultural sensibility? A comparison of two ideal type models to teach cultural diversity to medical students. *International Journal of Medicine*, 5, 223–231.
- Dogra, N., Giordano, J., & France, N. (2007). Cultural diversity teaching and issues of uncertainty: the findings of a qualitative study. *BMC Medical Education*, 7(1), 8. <https://doi.org/10.1186/1472-6920-7-8>

- Dogra, N., Reitmanova, S., & Carter-Pokras, O. (2009). Twelve tips for teaching diversity and embedding it in the medical curriculum. *Medical Teacher*, 31(11), 990–993.  
<https://doi.org/10.3109/01421590902960326>
- Douglas, M. K., Pierce, J. U., Rosenkoetter, M., Pacquiao, D., Callister, L. C., Hattar-Pollara, M., ... Purnell, L. (2011). Standards of Practice for Culturally Competent Nursing Care: 2011 Update. *Journal of Transcultural Nursing*, 22(4), 317–333.  
<https://doi.org/10.1177/1043659611412965>
- Durie, M. (2001). Cultural Competence and Medical Practice in New Zealand. Presented at the Australian and New Zealand Boards and Council Conference, Palmerston North, New Zealand.
- Dysart-Gale, D. (2006). Cultural sensitivity beyond ethnicity: A universal precautions model. *The Internet Journal of Allied Health Sciences and Practice*, 4(1), 1–4.
- Earley, P. C., & Ang, S. (2003). *Cultural Intelligence: Individual Interactions Across Cultures*. Stanford University Press.
- Entwistle. (1996). Recent research on student learning and the learning environment. In Jo Tait, Peter Knight, & Staff and Educational Development Association (Eds.), *The management of independent learning*. London: Kogan Page.
- Entwistle, N. (1997). Contrasting Perspectives on Learning. In F. Marton, D. Hounsell, & N. Entwistle (Eds.), *The Experience of Learning* (pp. 3–22). Edinburgh: Scottish Academic Press.
- Epstein, R. M. (1999). Mindful practice. *JAMA : The Journal of the American Medical Association*, 282(9), 833–839.
- Ertmer, P. A., Ottenbreit-Leftwich, A. T., Sadik, O., Sendurur, E., & Sendurur, P. (2012). Teacher beliefs and technology integration practices: A critical relationship. *Computers & Education*, 59(2), 423–435.  
<https://doi.org/10.1016/j.compedu.2012.02.001>

- Eva, K. W., & Regehr, G. (2008). “I’ll never play professional football” and other fallacies of self-assessment. *Journal of Continuing Education in the Health Professions*, 28(1), 14–19. <https://doi.org/10.1002/chp.150>
- Faculty of Medicine. (2009). Guide to the Early Learning in Medicine Curriculum 2009. University of Otago.
- Faculty of Medicine. (2011). Bachelor of Medicine and Bachelor of Surgery (MB ChB): A guide to the Otago undergraduate medical degree. University of Otago.
- Faculty of Medicine. (2014). Early Learning in Medicine Tutor Manual 2014. University of Otago Faculty of Medicine.
- Fendler, L. (2003). Teacher Reflection in a Hall of Mirrors: Historical Influences and Political Reverberations. *Educational Researcher*, 32(3), 16–25.
- Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209–230. <https://doi.org/10.1177/146879410200200205>
- Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From Mastery to Accountability: Cultural Humility as an Alternative to Cultural Competence. *Social Work Education*, 34(2), 165–181. <https://doi.org/10.1080/02615479.2014.977244>
- Fitzgerald, M. H. (2000). Establishing Cultural Competency in Mental Health Professionals. In V. Skultans & J. L. Cox (Eds.), *Anthropological approaches to psychological medicine: crossing bridges* (pp. 184–200). London: Jessica Kingsley Publishers.
- Fitzgerald, M. H. (2001). Gaining Knowledge of culture during professional education. In J. Higgs & A. Titchen (Eds.), *Practice knowledge and expertise in the health professions*. Oxford: Butterworth-Heinemann.



- Flick, U., von Kardoff, E., & Steinke, I. (2004). What is Qualitative Research? An Introduction to the Field. In U. Flick, E. von Kardoff, & I. Steinke (Eds.), *A Companion to Qualitative Research* (pp. 3–11). London: SAGE Publications.
- Fook, J. (2010). Beyond Reflective Practice: Reworking the “critical” in critical reflection. In H. Bradbury (Ed.), *Beyond reflective practice: new approaches to professional lifelong learning*. New York: Routledge.
- Fook, J., & Askeland, G. A. (2006). The ‘critical’ in critical reflection. In S. White, J. Fook, & F. Gardner (Eds.), *Critical reflection in health and social care* (pp. 40–53). Berkshire, England; New York: Open University Press.
- Fook, J., & Gardner, F. (2012). *Critical Reflection in Context: Applications in Health and Social Care*. Hoboken: Taylor and Francis.
- Foronda, C., Baptiste, D.-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural Humility: A Concept Analysis. *Journal of Transcultural Nursing*, 27(3), 210–217.  
<https://doi.org/10.1177/1043659615592677>
- Freeman, M., Treleaven, L., Ramburuth, P., Leask, B., Caulfield, N., Simpson, L., ... Sykes, C. (2009). *Embedding development of intercultural competence in Business Education*. Sydney: Australian Learning & Teaching Council.
- Fuller, J. (2003). Intercultural Health Care as Reflective Negotiated Practice. *Western Journal of Nursing Research*, 25(7), 781–797. <https://doi.org/10.1177/0193945903256710>
- Garrison, D. R. (2003). Cognitive presence for effective asynchronous online learning: The role of reflective inquiry, self-direction and metacognition. *Elements of Quality Online Education: Practice and Direction*, 4, 47–58.
- Garrison, D. R. (2011). *E-Learning in the 21st Century: A Framework for Research and Practice*. Taylor & Francis.

- Garrison, D. R., & Arbaugh, J. B. (2007). Researching the community of inquiry framework: Review, issues, and future directions. *The Internet and Higher Education*, 10(3), 157–172. <https://doi.org/10.1016/j.ihteduc.2007.04.001>
- Garrison, D. R., & Cleveland-Innes, M. (2005). Facilitating Cognitive Presence in Online Learning: Interaction is Not Enough. *American Journal of Distance Education*, 19(3), 133–148. [https://doi.org/10.1207/s15389286ajde1903\\_2](https://doi.org/10.1207/s15389286ajde1903_2)
- Garrison, R. R., Anderson, T., & Archer, W. (2000). Critical Inquiry in a Text-Based Environment: Computer Conferencing in Higher Education. *The Internet and Higher Education*, 2(2–3), 87–105. [https://doi.org/10.1016/S1096-7516\(00\)00016-6](https://doi.org/10.1016/S1096-7516(00)00016-6)
- Gerbic, P. (2006). Chinese Learners and Online Discussions: New Opportunities for Multicultural Classrooms. *Research and Practice in Technology Enhanced Learning*, 1(3), 221–237.
- Gilbert, J. (2006). Reflecting on intercultural dialogue in nursing. *Texto & Contexto - Enfermagem*, 15(1), 131–136. <https://doi.org/10.1590/S0104-07072006000100016>
- Gilbert, P. K., & Dabbagh, N. (2005). How to structure online discussions for meaningful discourse: a case study. *British Journal of Educational Technology*, 36(1), 5–18. <https://doi.org/10.1111/j.1467-8535.2005.00434.x>
- Goodfellow, R., & Hewling, A. (2005). Reconceptualising Culture in Virtual Learning Environments: from an ‘essentialist’ to a ‘negotiated’ perspective. *E-Learning and Digital Media*, 2(4), 355–367.
- Gordon, M. M. (1947). The Concept of the Sub-Culture and Its Application. *The Social Forces*, 26(40).
- Grainger-Monsen, M. (2007). *Hold Your Breath: A Journey into Cross-Cultural Medicine*. Stanford Center for Biomedical Ethics. Retrieved from <http://medethicsfilms.stanford.edu/holdyourbreath/>

- Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, 13(1), 10–28.  
<https://doi.org/10.5172/conu.13.1.10>
- Gray, B. (2014). *How does the concept of cultural competence affect the practice of bioethics and health law* (Thesis). University of Otago. Retrieved from  
<https://ourarchive.otago.ac.nz/handle/10523/5472>
- Gray, B. (2016). Clinical Ethics Cultural Competence and the Importance of Dialogue a Case Study. *Journal of Clinical Research & Bioethics*, 07(01), 1–6.  
<https://doi.org/10.4172/2155-9627.1000256>
- Gray, K., & Tobin, J. (2010). Introducing an online community into a clinical education setting: a pilot study of student and staff engagement and outcomes using blended learning. *BMC Medical Education*, 10(1), 6–6. <https://doi.org/10.1186/1472-6920-10-6>
- Green, A. R., Bentancourt, J. R., & Carrillo, J. E. (2002). Integrating Social Factors into Cross- cultural Medical Education: Academic Medicine. *Academic Medicine*, 77(3), 193–197.
- Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients. *Journal of General Internal Medicine*, 22(9), 1231–1238. <https://doi.org/10.1007/s11606-007-0258-5>
- Green, J., Willis, K., Hughes, E., Small, R., Welch, N., Gibbs, L., & Daly, J. (2007). Generating best evidence from qualitative research: the role of data analysis. *Australian and New Zealand Journal of Public Health*, 31(6), 545–550.  
<https://doi.org/10.1111/j.1753-6405.2007.00141.x>

- Greenwood, J. (1998). The role of reflection in single and double loop learning. *Journal of Advanced Nursing*, 27(5), 1048–1053. <https://doi.org/10.1046/j.1365-2648.1998.00579.x>
- Gregg, J., & Saha, S. (2006). Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education. *Academic Medicine* June 2006, 81(6), 542–547. <https://doi.org/10.1097/01.ACM.0000225218.15207.30>
- Grossman, R. (2009). Structures for Facilitating Student Reflection. *College Teaching*, 57(1), 15–22.
- Gudykunst, W., & Mody, B. (2002). *Handbook of international and intercultural communication*. Thousand Oaks, CA & London: SAGE Publications.
- Gudykunst, W. B., & Kim, Y. (2003). *Communicating with strangers: an approach to intercultural communication* (4th ed.). New York NY: Random House.
- Guillemin, M., & Gillam, L. (2004). Ethics, Reflexivity, and “Ethically Important Moments” in Research. *Qualitative Inquiry*, 10(2), 261–280. <https://doi.org/10.1177/1077800403262360>
- Guldborg, K., & Pilkington, R. (2007). Tutor roles in Facilitating Reflection on Practice Through Online Discussion. *Journal of Educational Technology & Society*, 10(1), 61–72.
- Guo, W., Chen, Y., Lei, J., & Wen, Y. (2014). The Effects of Facilitating Feedback on Online Learners’ Cognitive Engagement: Evidence from the Asynchronous Online Discussion. *Education Sciences*, 4(2), 193–208. <https://doi.org/10.3390/educsci4020193>
- Habermas, J. (1971). *Knowledge and human interests*. Boston: Beacon Press.
- Hager, M. (2005). Using German websites to teach culture in German courses. *CALICO Journal*, 22(2), 269–284.

- Hamilton, J. (2009). Intercultural competence in medical education - essential to acquire, difficult to assess. *Medical Teacher*, 31(9), 862–862.  
<https://doi.org/10.1080/01421590802530906>
- Hammer, M. R. (2011). Additional cross-cultural validity testing of the Intercultural Development Inventory. *International Journal of Intercultural Relations*, 35(4), 474–487.  
<https://doi.org/10.1016/j.ijintrel.2011.02.014>
- Hammer, M. R., Bennett, M. J., & Wiseman, R. (2003). Measuring intercultural sensitivity: The intercultural development inventory. *International Journal of Intercultural Relations*, 27(4), 421–443. [https://doi.org/10.1016/S0147-1767\(03\)00032-4](https://doi.org/10.1016/S0147-1767(03)00032-4)
- Harasim, L. (1993). Collaborating in Cyberspace: Using Computer Conferences as a Group Learning Environment. *Interactive Learning Environments*, 3(2), 119–130.  
<https://doi.org/10.1080/1049482930030202>
- Hargreaves, J. (2004). So how do you feel about that? Assessing reflective practice. *Nurse Education Today*, 24(3), 196–201. <https://doi.org/10.1016/j.nedt.2003.11.008>
- Harland, D. J., & Wondra, J. D. (2011). Preservice teachers' reflection on clinical experiences: a comparison of blog and final paper assignments. *Journal of Digital Learning in Teacher Education*, 27(4), 128.
- Harris, R., Cormack, D., Tobias, M., Yeh, L.-C., Talamaivao, N., Minster, J., & Timutimu, R. (2012). The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science & Medicine*, 74(3), 408–415. <https://doi.org/10.1016/j.socscimed.2011.11.004>
- Harrison, J., Lawson, T., & Wortley, A. (2005). Facilitating the professional learning of new teachers through critical reflection on practice during mentoring meetings. *European Journal of Teacher Education*, 28(3), 267–292.  
<https://doi.org/10.1080/02619760500269392>

- Harvey, T. (2017, July 25). The #1 Thing You Can Do to Help Students Navigate Cultural Differences. Retrieved July 30, 2017, from <http://www.truenorthintercultural.com/1/post/2017/07/the-1-thing-you-can-do-to-help-students-navigate-cultural-differences.html>
- Hatton, N., & Smith, D. (1995). Reflection in teacher education: Towards definition and implementation. *Teaching and Teacher Education*, 11(1), 33–49.  
[https://doi.org/10.1016/0742-051X\(94\)00012-U](https://doi.org/10.1016/0742-051X(94)00012-U)
- Health & Disability Commissioner. (1996). The HDC Code of Health and Disability Services Consumer's Right Regulations 1996. Retrieved from <http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-%28full%29>
- Hera, J. (2013). Cultural competence and patient centred care. In St. Geroge IM (Ed.), *Cole's medical practice in New Zealand* (12th ed., pp. 45–50). Wellington: Medical Council of New Zealand.
- Hibbard, S. T., Bellara, A. P., & Vermette, P. (2010). Evaluating the Use of Online Discussion Boards for Pre-service Teacher Learning. *International Journal of Learning*, 17(6), 175–186.
- Hofstede, G. (1980). *Culture's Consequences international differences in work-related values*. Beverly Hills, CA: Sage Publications. Retrieved from <http://otago.lconz.ac.nz/vwebv/holdingsInfo?searchId=898&recCount=25&recPoiner=1&bibId=175655>
- Hofstede, G. (2012). Dimensionalizing Cultures: The Hofstede Model in Context. In L. Samovar, R. Porter, & E. McDaniel (Eds.), *Intercultural Communication: A Reader* (pp. 19–33). Boston: Wadsworth Cengage Learning.
- Hofstede, G., & Bond, M. H. (1988). The Confucius connection: from cultural roots to economic growth. *Organizational Dynamics*, 16(4), 4–21.

- Hofstede, G. H., & Hofstede, G. J. (1991). *Cultures and organizations: software of the mind*. New York: McGraw-Hill.
- Hofstede, G., Hofstede, G. J. (2005). *Cultures and Organisation: Software of the Mind* (2nd ed.). New York: McGraw-Hill.
- Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and Organisation: Software of the Mind* (3rd ed.). New York: McGraw-Hill.
- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counselling Psychology, 60*(3), 353–366. <https://doi.org/10.1037/a0032595>
- Hunt, M. R. (2009). Strengths and Challenges in the Use of Interpretive Description: Reflections Arising From a Study of the Moral Experience of Health Professionals in Humanitarian Work. *Qualitative Health Research, 19*(9), 1284–1292. <https://doi.org/10.1177/1049732309344612>
- Hwang, G.-J., & Tsai, C.-C. (2011). Research trends in mobile and ubiquitous learning: a review of publications in selected journals from 2001 to 2010. *British Journal of Educational Technology, 42*(4), E65–E70. <https://doi.org/10.1111/j.1467-8535.2011.01183.x>
- Jackson, J. (2011). Cultivating cosmopolitan, intercultural citizenship through critical reflection and international, experiential learning. *Language and Intercultural Communication, 11*(2), 80–96. <https://doi.org/10.1080/14708477.2011.556737>
- Javidan, M., & Teagarden, M. B. (2011). Conceptualizing and measuring global mindset. In *Advances in Global Leadership* (Vol. 6, pp. 13–39). Emerald Group Publishing Limited. [https://doi.org/10.1108/S1535-1203\(2011\)0000006005](https://doi.org/10.1108/S1535-1203(2011)0000006005)
- Jin, J. (2012). Sounds of Silence: Examining Silence in Problem-Based Learning (PBL) in Asia. In S. Bridges, C. McGrath, & T. L. Whitehill (Eds.), *Problem-Based Learning in*

- Clinical Education* (pp. 171–188). Netherlands: Springer, Dordrecht.  
[https://doi.org/10.1007/978-94-007-2515-7\\_11](https://doi.org/10.1007/978-94-007-2515-7_11)
- Jonassen, D., Davidson, M., Collins, M., Campbell, J., & Haag, B. B. (1995).  
 Constructivism and computer- mediated communication in distance education.  
*American Journal of Distance Education*, 9(2), 7–26.  
<https://doi.org/10.1080/08923649509526885>
- Jones, M., & Ryan, J. (2014). Learning in the practicum: engaging pre-service teachers in  
 reflective practice in the online space. *Asia-Pacific Journal of Teacher Education*, 0(0),  
 1–15. <https://doi.org/10.1080/1359866X.2014.892058>
- Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A Strategy to Reduce Cross-cultural  
 Miscommunication and Increase the Likelihood of Improving Health Outcomes.  
*Academic Medicine*, 78(6), 577–587.
- Kanuka, H., Rourke, L., & Laflamme, E. (2007). The influence of instructional methods  
 on the quality of online discussion. *British Journal of Educational Technology*, 38(2),  
 260–271. <https://doi.org/10.1111/j.1467-8535.2006.00620.x>
- Kember, D. (2008). *Reflective teaching and learning in the health professions: Action research in  
 professional education*. John Wiley & Sons.
- Kember, D., Leung, D. Y. P., Jones, A., Loke, A. Y., McKay, J., Sinclair, K., ... Yeung, E.  
 (2000). Development of a Questionnaire to Measure the Level of Reflective  
 Thinking. *Assessment & Evaluation in Higher Education*, 25(4).  
<https://doi.org/10.1080/713611442>
- Kember, D., McKay, J., Sinclair, K., & Wong, F. K. Y. (2008). A four- category scheme  
 for coding and assessing the level of reflection in written work. *Assessment &  
 Evaluation in Higher Education*, 33(4), 369–379.  
<https://doi.org/10.1080/02602930701293355>



- Kember, D., Yeung, E., Jones, A., Loke, A., McKay, J., Sinclair, K., ... Wong, M. (1999). Determining the Level of Reflective Thinking from Students' Written Journals Using a Coding Scheme Based on the Work of Mezirow. *International Journal of Lifelong Education*, 18(1), 18–30. <https://doi.org/10.1080/026013799293928>
- Khalili, H., Orchard, C., Spence Laschinger, H. K., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional identity among health professions students. *Journal of Interprofessional Care*, 27(6), 448–453. <https://doi.org/10.3109/13561820.2013.804042>
- King, P. M., & Baxter Magolda, M. B. (2005). A Developmental Model of Intercultural Maturity. *Journal of College Student Development*, 46(6), 571–592.
- King, P. M., & Kitchener, K. S. (1994). *Developing reflective judgment: understanding and promoting intellectual growth and critical thinking in adolescents and adults*. San Francisco: Jossey-Bass Publishers.
- Kinsella, E. A. (2010). Professional knowledge and the epistemology of reflective practice. *Nursing Philosophy*, 11(1), 3–14. <https://doi.org/10.1111/j.1466-769X.2009.00428.x>
- Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Kling, R., & Courtright, C. (2003). Group Behaviour and Learning in Electronic Forums: A Sociotechnical Approach. *The Information Society*, 19(3), 221–235. <https://doi.org/10.1080/01972240309465>
- Kolb, D. A. (1984). *Experiential learning: experience as the source of learning and development*. Englewood Cliffs, N.J: Prentice-Hall.
- Kools, S., Chimwaza, A., & Macha, S. (2015). Cultural humility and working with marginalized populations in developing countries. *Global Health Promotion*, 22(1), 52–59. <https://doi.org/10.1177/1757975914528728>

- Krieger, N. (2001). A glossary for social epidemiology. *Journal of Epidemiology and Community Health*, 55(10), 693–700. <https://doi.org/10.1136/jech.55.10.693>
- Krieger, N. (2005). Embodiment: a conceptual glossary for epidemiology. *Journal of Epidemiology & Community Health*, 59(5), 350–355. <https://doi.org/10.1136/jech.2004.024562>
- Kumagai, A. K., & Lypson, M. L. (2009). Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education. *Academic Medicine*, 84(6), 782–787. <https://doi.org/10.1097/ACM.0b013e3181a42398>
- Kuper, A., Veinot, P., Leavitt, J., Levitt, S., Li, A., Goguen, J., ... Whitehead, C. R. (2017). Epistemology, culture, justice and power: non-bioscientific knowledge for medical training. *Medical Education*, 51(2), 158–173. <https://doi.org/10.1111/medu.13115>
- Lachman, N., & Pawlina, W. (2006). Integrating professionalism in early medical education: The theory and application of reflective practice in the anatomy curriculum. *Clinical Anatomy*, 19(5), 456–460. <https://doi.org/10.1002/ca.20344>
- Lai, T., & Land, S. M. (2009b). Supporting Reflection in Online Learning Environments. In M. Orey, V. J. McClendon, & R. M. Branch (Eds.), *Educational Media and Technology Yearbook* (Vol. 34, pp. 141–154). Boston, MA: Springer US.
- Lam, W. S. E. (2004). Second language socialization in a bilingual chat room: Global and local considerations. *Language Learning & Technology*, 8(3), 44–65.
- Lather, P. (2006). Paradigm proliferation as a good thing to think with: teaching research in education as a wild profusion. *International Journal of Qualitative Studies in Education*, 19(1), 35–57. <https://doi.org/10.1080/09518390500450144>
- Laurillard, D. (2009). The pedagogical challenges to collaborative technologies. *International Journal of Computer-Supported Collaborative Learning*, 4(1), 5–20. <https://doi.org/10.1007/s11412-008-9056-2>

- Lee, O. (2010). Facilitating Preservice Teachers' Reflection through Interactive Online Journal Writing - ProQuest. *Physical Educator*, 67(3), 128–139.
- Leung, D. Y. P., & Kember, D. (2003). The Relationship between Approaches to Learning and Reflection upon Practice. *Educational Psychology: An International Journal of Experimental Educational Psychology*, 23(1), 61–71.  
<https://doi.org/10.1080/01443410303221>
- Leung, K., Ang, S., & Tan, M. L. (2014). Intercultural Competence. *Annual Review of Organizational Psychology and Organizational Behavior*, 1(1), 489–519.  
<https://doi.org/10.1146/annurev-orgpsych-031413-091229>
- Leung, K., & Cheng, G. H.-L. (2014). Adaptability and Intercultural Interactions in the Work Context: A Cultural Tuning Perspective. In D. Chan (Ed.), *Individual Adaptability to Changes at Work: New Directions in Research* (pp. 156–174). New York: Routledge.
- Levine, J. S. (2007). The Online Discussion Board. *New Directions for Adult and Continuing Education*, (113), 67–74. <https://doi.org/10.1002/ace.248>
- Levinson, W., Gorawara-Bhat, R. & Lamb, J. (2000). A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings. *JAMA*, 284(8), 1021-1027.
- Liaw, M.-L. (2008). E-Learning and the Development of Intercultural Competence. *Language Learning & Technology*, 10(3).
- Lie, D., Shapiro, J., Cohn, F., & Najm, W. (2010). Reflective practice enriches clerkship students' cross-cultural experiences. *Journal of General Internal Medicine*, 25 Suppl 2(5), S119–S125. <https://doi.org/10.1007/s11606-009-1205-4>
- Liimatainen, L., Poskiparta, M., Karhila, P., & Sjögren, A. (2001). The development of reflective learning in the context of health counselling and health promotion during

- nurse education. *Journal of Advanced Nursing*, 34(5), 648–658.  
<https://doi.org/10.1046/j.1365-2648.2001.01794.x>
- Lin, X., & Lehman, J. D. (1999). Supporting learning of variable control in a computer-based biology environment: Effects of prompting college students to reflect on their own thinking. *Journal of Research in Science Teaching*, 36(7), 837–858.  
[https://doi.org/10.1002/\(SICI\)1098-2736\(199909\)36:7<837::AID-TEA6>3.0.CO;2-U](https://doi.org/10.1002/(SICI)1098-2736(199909)36:7<837::AID-TEA6>3.0.CO;2-U)
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Thousand Oaks, CA & London: SAGE.
- Lloyd, S., & Härtel, C. (2010). Intercultural competencies for culturally diverse work teams. *Journal of Managerial Psychology*, 25(8), 845–875.  
<https://doi.org/10.1108/02683941011089125>
- Lupton, D. (2012). Medicine as Culture: Illness, Disease and the Body. In *Medicine as Culture: Illness, Disease and the Body* (Third, pp. 105–150). Thousand Oaks, CA & London: SAGE.
- Lyons, N. (2010). Reflection and Reflective Inquiry: Critical Issues, Evolving Conceptualizations, Contemporary Claims and Future Possibilities. In N. Lyons (Ed.), *Handbook of Reflection and Reflective Inquiry* (pp. 3–22). Boston, MA: Springer.  
[https://doi.org/10.1007/978-0-387-85744-2\\_1](https://doi.org/10.1007/978-0-387-85744-2_1)
- Ma, A. W. W. (2010). Computer Supported Collaborative Learning and Critical Reflection: A Case Study of Fashion Consumerism. *Interdisciplinary Journal of E-Learning & Learning Objects*, 6, 87–102.
- Macfarlane, B. (2015). Student performativity in higher education: converting learning as a private space into a public performance. *Higher Education Research & Development*, 34(2), 338–350. <https://doi.org/10.1080/07294360.2014.956697>

- Mamede, S., & Schmidt, H. G. (2005). Correlates of Reflective Practice in Medicine. *Advances in Health Sciences Education*, 10(4), 327–337.  
<https://doi.org/10.1007/s10459-005-5066-2>
- Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Science Education*, 14, 595–621. <https://doi.org/10.1007/s10459-007-9090-2>
- Marton, F., Dall’Alba, G., & Beaty, E. (1993). Conceptions of Learning. *International Journal of Educational Research*, 19(3), 277–300.
- Marton, F., & Säljö, R. (1976). On Qualitative Differences in Learning—li Outcome as a Function of the Learner’s Conception of the Task. *British Journal of Educational Psychology*, 46(2), 115–127. <https://doi.org/10.1111/j.2044-8279.1976.tb02304.x>
- Matsumoto, D. (2000). *Culture and psychology* (2nd ed.). Pacific Grove, CA: Brooks Cole Publishing Co.
- Matsumoto, D., LeRoux, J., Ratzlaff, C., Tatani, H., Uchida, H., Kim, C., & Araki, S. (2001). Development and validation of a measure of intercultural adjustment potential in Japanese sojourners: The Intercultural Adjustment Potential Scale (ICAPS). *International Journal of Intercultural Relations*, 25(5), 483–510.  
[https://doi.org/10.1016/S0147-1767\(01\)00019-0](https://doi.org/10.1016/S0147-1767(01)00019-0)
- Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research : a philosophic and practical guide*. London; Washington, DC: Falmer Press.
- McAllister, L., Whiteford, G., Hill, B., Thomas, N., & Fitzgerald, M. (2006). Reflection in intercultural learning: examining the international experience through a critical incident approach. *Reflective Practice*, 7(3), 367–381.  
<https://doi.org/10.1080/14623940600837624>
- McPherson, K. M., & McNaughton, H. K. (2003). Ethnicity, equity, and quality: Lessons from New Zealand. *British Medical Journal*, 327, 443–444.

- Means, B., Toyama, Y., Murphy, R., Bakia, M., & Jones, K. (2010). *Evaluation of Evidence-Based Practices in Online Learning: A Meta-Analysis and Review of Online Learning Studies*. Jessup, MD: US Department of Education. Retrieved from <http://www.edpubs.org>
- Medical Council of New Zealand. (2006). Statement on cultural competence. Medical Council of New Zealand. Retrieved from [www.mcnz.org.nz](http://www.mcnz.org.nz)
- Mezirow, J. (1990). How Critical Reflection Triggers Transformative Learning. In J. Mezirow (Ed.), *Fostering critical reflection in adulthood: a guide to transformative and emancipatory learning* (pp. 1–19). San Francisco: Jossey-Bass Publishers.
- Mezirow, J. (1991). *Transformative Dimensions of Adult Learning*. San Francisco, CA: Jossey-Bass.
- Mezirow, J. (1998). On critical reflection. *Adult Education Quarterly*, 48(3), 185.
- Mezirow, J. (2000). Learning to Think Like an Adult: Core Concepts of Transformation Theory. In J. Mezirow (Ed.), *Learning as transformation: critical perspectives on a theory in progress* (pp. 3–34). San Francisco: Jossey-Bass.
- Mezirow, J. (2009). An overview on transformative learning. In K. Illeris (Ed.), *Contemporary theories of learning: learning theorists... in their own words* (pp. 91–105). New York: Routledge.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage.
- Miller, M. D. (2014). *Minds Online: Teaching Effectively with Technology*. Harvard University Press.
- Minichiello, V., & Kottler, J. A. (2010). An Overview of the Qualitative Journey: Review Basic Concepts. In V. Minichiello & J. A. Kottler (Eds.), *Qualitative Journeys: Student and Mentor Experiences with Research* (pp. 11–31). Thousand Oaks, CA & London: SAGE Publications Inc.

- Ministry of Health. (2003). Health Practitioners Competence Assurance Act 2003 Section 118i. Ministry of Health New Zealand. Retrieved from <http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM204334.html>
- Ministry of Health New Zealand. (2015). He Korowai Oranga: Māori Health Strategy. Retrieved February 5, 2018, from <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>
- Mintz, S. (2009). Transformational Teaching. Columbia Teaching Centre. Retrieved from <http://www.columbia.edu/cu/tat/pdfs/Transformational%20Teaching.pdf>
- Moll, L. C., & Greenburg, J. B. (1992). Creating zones of possibilities: Combining social contexts for instruction. In L. C. Moll (Ed.), *Vygotsky and education: instructional implications and applications of sociocultural psychology* (pp. 319–348). Cambridge: Cambridge University Press.
- Moon, D. G. (2008). Concepts of culture. Implications for intercultural communication research. In Molefi Kete Asante, Yoshitaka Miike, & Jing Yin (Eds.), *The global intercultural communication reader*. London; New York: Routledge.
- Moon, J. (2007). Getting the measure of reflection: considering matters of definition and depth. *Journal of Radiotherapy in Practice*, 6(4), 191. <https://doi.org/10.1017/S1460396907006188>
- Moon, J. A. (1999). *Reflection in learning and professional development: theory and practice*. London: Kogan Page.
- Moon, J. A. (2013). *Reflection in Learning and Professional Development: Theory and Practice*. Hoboken: Taylor and Francis.
- Moore, M. G., Shattuck, K., & Al-Harthi, A. (2005). Cultures meeting cultures in online distance education. *Journal of E-Learning and Knowledge Society*, 2(2). Retrieved from <http://services.economia.unitn.it/ojs/index.php/Je-LKS/article/viewArticle/64>

- Morell, V. W., Sharp, P. C., & Crandall, S. J. (2002). Creating student awareness to improve cultural competence: creating the critical incident. *Medical Teacher*, 24(5), 532–534. <https://doi.org/10.1080/0142159021000012577>
- Muñoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International*, 14(4), 256–280. <https://doi.org/10.1002/oti.238>
- Murphy, E. (2004). Identifying and Measuring Ill-Structured Problem Formulation and Resolution in Online Asynchronous Discussions. *Canadian Journal of Learning and Technology / La Revue Canadienne de l'apprentissage et de La Technologie*, 30(1). Retrieved from <http://cjlt.csj.ualberta.ca/index.php/cjlt/article/view/122>
- Nagata, A. L. (2004). Promoting self-reflexivity in intercultural education. *Journal of Intercultural Communication*, 8, 139–167.
- New Zealand Government. (2011). New Zealand Public Health and Disability Amendment Act 2010. Retrieved February 5, 2018, from <http://www.legislation.govt.nz/act/public/2010/0118/32.0/DLM2901027.html>
- Nguyen, Q. D., Fernandez, N., Karsenti, T., & Charlin, B. (2014). What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Medical Education*, 48(12), 1176–1189. <https://doi.org/10.1111/medu.12583>
- Nursing Council of New Zealand. (2005). Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. Nursing Council of New Zealand. Retrieved from <http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses>
- Nursing Council of New Zealand. (2011). Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice. Nursing Council of New Zealand. Retrieved from



<http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses>

Ong, K. (2011). Reflection for action in the medical field. *Reflective Practice*, 12(1), 145–149.

<https://doi.org/10.1080/14623943.2011.541102>

Orange, C. (2015). *The Treaty of Waitangi*. Wellington, NZ: Bridget Williams Books.

Orr, R. D., Marshall, P. A., & Osborn, J. (1995). Cross-cultural considerations in clinical ethics consultations. *Archives of Family Medicine*, 4(2), 159.

<https://doi.org/10.1001/archfami.1995.018502700850019>

Paige, M. R., Jacobs-Cassuto, M., Yershova, Y. A., & DeJaeghere, J. (2003). Assessing intercultural sensitivity: an empirical analysis of the Hammer and Bennett Intercultural Development Inventory. *International Journal of Intercultural Relations*, 27(4), 467–486. [https://doi.org/10.1016/S0147-1767\(03\)00034-8](https://doi.org/10.1016/S0147-1767(03)00034-8)

Palincsar, A. S. (1998). Social constructivist perspectives on teaching and learning. *Annual Review of Psychology*, 49(1), 345.

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: the New Zealand Experience. *International Journal for Quality in Health Care*, 8(5), 491–497.

<https://doi.org/10.1093/intqhc/8.5.491>

Parker, D., & Gemino, A. (2001). Inside online learning: Comparing conceptual and technique learning performance in place-based and ALN formats. *Journal of Asynchronous Learning Networks*, 5(2), 64–74.

Patton, M. Q. (2005). Qualitative Research. In *Encyclopedia of Statistics in Behavioral Science*. John Wiley & Sons, Ltd. <https://doi.org/10.1002/0470013192.bsa514>

Paulo Freire. (1970). *Pedagogy of the oppressed*. New York Herder and Herder.

Pawan, F., Paulus, T. M., Yalcin, S., & Chang, C.-F. (2003). Online Learning: Patterns of Engagement and Interaction Among In-service Teachers. *Language Learning & Technology*, 7(3), 119–140.

- Pearson, D. J., & Heywood, P. (2004). Portfolio use in general practice vocational training: a survey of GP registrars. *Medical Education*, 38(1), 87–95.
- Pee, B., Woodman, T., Fry, H., & Davenport, E. S. (2002). Appraising and assessing reflection in students' writing on a structured worksheet. *Medical Education*, 36(6), 575–585. <https://doi.org/10.1046/j.1365-2923.2002.01227.x>
- Perlman, R. L., Ross, P. T., Christner, J., & Lypson, M. L. (2011). Faculty reflections on the implementation of socio- cultural eportfolio assessment tool. *Reflective Practice*, 12(3), 375–388. <https://doi.org/10.1080/14623943.2011.571868>
- Perry, L. B., & Southwell, L. (2011). Developing intercultural understanding and skills: models and approaches. *Intercultural Education*, 22(6), 453–466. <https://doi.org/10.1080/14675986.2011.644948>
- Picciano, A. G. (2002). Beyond student perceptions: Issues of interaction, presence, and performance in an online course. *Journal of Asynchronous Learning Networks*, 6(1), 21–40.
- Plack, M. M., Driscoll, M., Blissett, S., McKenna, R., & Plack, T. P. (2005). A Method for Assessing Reflective Journal Writing. *Journal of Allied Health*, 34(4), 199–199.
- Plack, M. M., Dunfee, H., Rindflesch, A., & Driscoll, M. (2008). Virtual Action Learning Sets: A Model for Facilitating Reflection in the Clinical Setting. *Journal of Physical Therapy Education*, 22(3), 33–42.
- Plack, M. M., Dunfee, H., Rindflesch, A., & Driscoll, M. (2008). Virtual Action Learning Sets: A Model for Facilitating Reflection in the Clinical Setting. *Journal of Physical Therapy Education*, 22(3), 33–42.
- Plack, M. M., & Greenberg, L. (2005). The Reflective Practitioner: Reaching for Excellence in Practice. *Pediatrics*, 116(6), 1546–1552. <https://doi.org/10.1542/peds.2005-0209>

- Platzer, H., Blake, D., & Ashford, D. (2000). Barriers to learning from reflection: a study of the use of groupwork with post-registration nurses. *Journal of Advanced Nursing*, 31(5), 1001-1008. <https://doi.org/10.1046/j.1365-2648.2000.01396.x>
- Plumpton, B. (2005). *How students can make conferencing work* (European Ph.D. on Social Representations and Communication International Lab Meetings: New Series 2005-2008). Open University.
- Poldner, E., Simons, P. R. J., Wijngaards, G., & van der Schaaf, M. F. (2012). Quantitative content analysis procedures to analyse students' reflective essays: A methodological review of psychometric and edumetric aspects. *Educational Research Review*, 7(1), 19–37. <https://doi.org/10.1016/j.edurev.2011.11.002>
- Pollard, K. C., Miers, M. E., & Rickaby, C. (2012). “Oh why didn't I take more notice?” Professionals' views and perceptions of pre-qualifying preparation for interprofessional working in practice. *Journal of Interprofessional Care*, 26(5), 355–361. <https://doi.org/10.3109/13561820.2012.689785>
- Ramsden, I. (1993). Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing Praxis in New Zealand Inc*, 8(3), 4–10.
- Reeder, K., Macfayden, L. P., Roche, J., & Chase, M. (2004). Negotiating cultures in cyberspace: participation patterns and problematics. *Language Learning & Technology*, 8(2), 88–105.
- Reis, S. P., Wald, H. S., Monroe, A. D., & Borkan, J. M. (2010). Begin the BEGAN (The Brown Educational Guide to the Analysis of Narrative) – A framework for enhancing educational impact of faculty feedback to students' reflective writing. *Patient Education and Counseling*, 80(2), 253–259. <https://doi.org/10.1016/j.pec.2009.11.014>

- Reitmanova, S. (2011). Cross-Cultural Undergraduate Medical Education in North America: Theoretical Concepts and Educational Approaches. *Teaching and Learning in Medicine*, 23(2), 197–203. <https://doi.org/10.1080/10401334.2011.561761>
- Roberts, C. (2007). Intercultural communication in healthcare settings. In H. Kotthoff & H. Spencer-Oatley (Eds.), *Handbook of Intercultural Communication* (pp. 243–262). New York: Walter de Gruyter.
- Roberts, J. H., Sanders, T., Mann, K., & Wass, V. (2010). Institutional marginalisation and student resistance: barriers to learning about culture, race and ethnicity. *Advances in Health Sciences Education: Theory and Practice*, 15(4), 559–571. <https://doi.org/10.1007/s10459-010-9218-7>
- Robson, B., & Harris, R. (2007). *Hauora: Māori Standards of Health IV. A study of the years 2000-2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, School of Medicine and Health Sciences, University of Otago. Retrieved from <http://www.otago.ac.nz/wellington/research/erupomare/projects/otago019494.html>
- Robson, C. (1993). *Real world research: A resource of social scientists and practioner-readers*. Massachusetts: Blackwell Pushers.
- Rodgers, C. (2002). Defining reflection: Another look at John Dewey and reflective thinking. *Teachers College Record*, 104(4), 842–866. <https://doi.org/10.1111/1467-9620.00181>
- Rogers, R. R. (2001). Reflection in Higher Education: A Concept Analysis. *Innovative Higher Education*, 26(1), 37–57. <https://doi.org/10.1023/A:1010986404527>
- Ross, J. (2011). Traces of self: online reflective practices and performances in higher education. *Teaching in Higher Education*, 16(1), 113–126. <https://doi.org/10.1080/13562517.2011.530753>

- Ross, J. (2012). Just What Is Being Reflected in Online Reflection? New Literacies for New Media Learning Practices. In L. Dirckinck-Holmfeld, V. Hodgson, & D. McConnell (Eds.), *Exploring the Theory, Pedagogy and Practice of Networked Learning* (pp. 191–207). Springer New York. Retrieved from [http://link.springer.com/chapter/10.1007/978-1-4614-0496-5\\_11](http://link.springer.com/chapter/10.1007/978-1-4614-0496-5_11)
- Rourke, L., & Kanuka, H. (2009). Learning in Communities of Inquiry: A Review of the Literature. *Journal of Distance Education*, 23(1), 19–47.
- Royal Commission on Social Policy. (1988). *The April report: Royal Commission on Social Policy*. Wellington, NZ: Royal Commission on Social Policy.
- Rubin, R. W. (2004). Developing cultural competence and social responsibility in preclinical dental students. *Journal of Dental Education*, 68(4), 460–467.
- Ryan, M. (2013). The pedagogical balancing act: teaching reflection in higher education. *Teaching in Higher Education*, 18(2), 144–155.  
<https://doi.org/10.1080/13562517.2012.694104>
- Ryan, M., & Ryan, M. (2013). Theorising a model for teaching and assessing reflective learning in higher education. *Higher Education Research & Development*, 32(2), 244–257. <https://doi.org/10.1080/07294360.2012.661704>
- Sandars, J. (2009). The use of reflection in medical education: AMEE Guide No. 44. *Medical Teacher*, 31(8), 685–695. <https://doi.org/10.1080/01421590903050374>
- Scardamalia, M., & Bereiter, C. (1994). Computer Support for Knowledge-Building Communities. *Journal of the Learning Sciences*, 3(3), 265–283.  
[https://doi.org/10.1207/s15327809jls0303\\_3](https://doi.org/10.1207/s15327809jls0303_3)
- Scardamalia, M., Bereiter, C., McLean, R. S., Swallow, J., & Woodruff, E. (1989). Computer-Supported Intentional Learning Environments. *Journal of Educational Computing Research*, 5(1), 51–68. <https://doi.org/10.2190/CYXD-6XG4-UFN5-YFB0>

- Schön, D. A. (1983). *The reflective practitioner: how professionals think in action*. New York: Basic Books.
- Schön, D. A. (1987). *Educating the reflective practitioner: toward a new design for teaching and learning in the professions*. San Francisco: Jossey-Bass.
- Schön, D. A. (1995). *The reflective practitioner: how professionals think in action*. Aldershot, Hants: Arena.
- Schuessler, J. B., Wilder, B., & Byrd, L. W. (2012). Reflective journaling and development of cultural humility in students. *Nursing Education Perspectives*, 33(2), 96.
- Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: a conceptual framework for teaching and learning. *Medical Education*, 43(3), 229–237.  
<https://doi.org/10.1111/j.1365-2923.2008.03269.x>
- Shaw, M., Lee, A., & Williams, R. (2015). Formative journeys of first-year college students: tensions and intersections with intercultural theory. *Higher Education Research & Development*, 34(1), 188–204. <https://doi.org/10.1080/07294360.2014.934330>
- Signorini, P., Wiesemes, R., & Murphy, R. (2009). Developing alternative frameworks for exploring intercultural learning: a critique of Hofstede's cultural difference model. *Teaching in Higher Education*, 14(3), 253–264.  
<https://doi.org/10.1080/13562510902898825>
- Smith, E. (2011). Teaching critical reflection. *Teaching in Higher Education*, 16(2), 211–223.  
<https://doi.org/10.1080/13562517.2010.515022>
- Sobral, D. T. (2001). Medical students' reflection in learning in relation to approaches to study and academic achievement. *Medical Teacher*, 2001, Vol.23(5), p.508-513, 23(5), 508–513. <https://doi.org/10.1080/01421590126488>
- Statistics New Zealand. (2013). *2013 Census QuickStats about culture and identity*. Wellington, NZ. Retrieved from <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity.aspx>

- Sthapornnanon, N., Sakulbumrungsil, R., Theeraroungchaisri, A., & Watcharadamrongkun, S. (2009). Social constructivist learning environment in an online professional practice course. *American Journal of Pharmaceutical Education*, 73(1), 10. <https://doi.org/10.5688/aj730110>
- Stier, J. (2006). Internationalisation, intercultural communication and intercultural competence. *Journal Of Intercultural Communication*, (11).
- Sullivan, A. (2003). Effecting change through electoral politics: cultural identity and the Maori franchise. *Journal of Polynesian Society*, 112(3), 219–237.
- Swan, K. (2005). A constructivist model for thinking about learning online. *Elements of Quality Online Education: Engaging Communities*, 6, 13–31.
- Swan, K., Shea, P., Richardson, J., Ice, P., Garrison, D. R., Cleveland-Innes, M., & Arbaugh, J. B. (2008). Validating a measurement tool of presence in online communities of inquiry. *E-Mentor*, 2(24), 1–12.
- Szabo, Z., & Schwartz, J. (2011). Learning methods for teacher education: the use of online discussions to improve critical thinking. *Technology, Pedagogy and Education*, 20(1), 79–94. <https://doi.org/10.1080/1475939X.2010.534866>
- Taylor, E. (2000). Teaching with developmental intention. In J. Mezirow (Ed.), *Learning as transformation: critical perspectives on a theory in progress* (1st ed., pp. 285–328). San Francisco: Jossey-Bass.
- Taylor, E. W. (1994). Intercultural Competency: A Transformative Learning Process. *Adult Education Quarterly*, 44(3), 154–174. <https://doi.org/10.1177/074171369404400303>
- Taylor, E. W. (2000). Analyzing Research on Transformative Learning Theory. In J. Mezirow (Ed.), *Learning as transformation: critical perspectives on a theory in progress* (pp. 285–328). San Francisco: Jossey-Bass.

- Taylor, E. W. (2007). An update of transformative learning theory: a critical review of the empirical research (1999–2005). *International Journal of Lifelong Education*, 26(2), 173–191. <https://doi.org/10.1080/02601370701219475>
- Taylor, E. W. (2008). Transformative learning theory. *New Directions for Adult & Continuing Education*, 2008(119), 5–15. <https://doi.org/10.1002/ace.301>
- Te Puni Kōkiri. (2014). Māori Language Strategy 2014. Te Puni Kōkiri. Retrieved from <https://www.tpk.govt.nz/en/a-matou-mohiotanga/language/maori-language-strategy-2014/>
- Tervalon, M. (2003). Components of culture in health for medical students' education. *Academic Medicine: Journal of the Association of American Medical Colleges*, 78(6), 570–576.
- Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117–125.
- Thomas, J. (2013). Exploring the use of asynchronous online discussion in health care education: A literature review. *Computers & Education*, 69, 199–215. <https://doi.org/10.1016/j.compedu.2013.07.005>
- Thompson, N., & Pascal, J. (2012). Developing critically reflective practice. *Reflective Practice*, 13(2), 311–325. <https://doi.org/10.1080/14623943.2012.657795>
- Thompson, S., & Thompson, N. (2008). *The critically reflective practitioner*. New York: Palgrave Macmillan.
- Thorne, S. L., Black, R. W., & Sykes, J. M. (2009). Second Language Use, Socialization, and Learning in Internet Interest Communities and Online Gaming. *The Modern Language Journal*, 93, 802–821. <https://doi.org/10.1111/j.1540-4781.2009.00974.x>
- Ting-Toomey, S. (2007). Intercultural Conflict Training: Theory-Practice Approaches and Research Challenges. *Journal of Intercultural Communication Research*, 36(3), 255–271. <https://doi.org/10.1080/17475750701737199>



- Trede, F., & Smith, M. (2012). Teaching reflective practice in practice settings: students' perceptions of their clinical educators. *Teaching in Higher Education*, 17(5), 615–627. <https://doi.org/10.1080/13562517.2012.658558>
- Triandis, H. C. (1990). Theoretic concepts that are applicable to the analysis of ethnocentrism. In R. W. Brislin (Ed.), *Applied Cross-Cultural Psychology* (Vol. 14, pp. 34–55). Newbury Park; London; New Delhi: SAGE Publications.
- Triandis, H. C. (1994). *Culture and social behavior*. McGraw-Hill Book Company.
- Trigwell, K., & Prosser, M. (1991). Improving the quality of student learning: the influence of learning context and student approaches to learning on learning outcomes. *Higher Education*, 22(3), 251–266. <https://doi.org/10.1007/BF00132290>
- Tudge, J. R. H. (1992). Processes and consequences of peer collaboration: A Vygotskian analysis. *Child Development*, 63(6), 1364–1379. <https://doi.org/10.1111/1467-8624.ep9308195007>
- Twible, R. L., & Henley, E. C. (2001). Transferring Professional Craft Knowledge Across Cultural Contexts. In J. Higgs & A. Titchen (Eds.), *Practice Knowledge and Expertise in the Health Professions* (pp. 157–164). Oxford: Butterworth-Heinemann.
- Van der Zee, K. I., & Van Oudenhoven, J. P. (2000). The multicultural personality questionnaire: a multidimensional instrument of multicultural effectiveness. *European Journal of Personality*, 14(4), 291–309.
- van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine*, 50(6), 813–828. [https://doi.org/10.1016/S0277-9536\(99\)00338-X](https://doi.org/10.1016/S0277-9536(99)00338-X)
- Vivekananda-Schmidt, P., Marshall, M., Stark, P., Mckendree, J., Sandars, J., & Smithson, S. (2011). Lessons from medical students' perceptions of learning reflective skills: A multi-institutional study. *Medical Teacher*, 33(10), 846–850. <https://doi.org/10.3109/0142159X.2011.577120>

- Vygotsky, L. S. (1978). *Mind in Society: the development of higher psychological processes*. Cambridge, MA: Harvard University Press.
- Wald, H., Borkan, J., Scott, J., Anthony, D., & Reis, S. P. (2012). Fostering and Evaluating Reflective Capacity in Medical Education: Developing the REFLECT Rubric for Assessing Reflective Writing. *Academic Medicine*, 87(1), 41–50.  
<https://doi.org/10.1097/ACM.0b013e31823b55fa>
- Wald, H., & Reis, S. P. (2010). Beyond the Margins: Reflective Writing and Development of Reflective Capacity in Medical Education. *Journal of General Internal Medicine*, 25(7), 746–749. <https://doi.org/10.1007/s11606-010-1347-4>
- Wald, H. S., Davis, S. W., Reis, S. P., Monroe, A. D., & Borkan, J. M. (2009). Reflecting on reflections: enhancement of medical education curriculum with structured field notes and guided feedback. *Academic Medicine: Journal of the Association of American Medical Colleges*, 84(7), 830–837.
- Wallman, A., Lindblad, A. K., Hall, S., Lundmark, A., & Ring, L. (2008). A categorization scheme for assessing pharmacy students' levels of reflection during internships. *American Journal of Pharmaceutical Education*, 72(1), 05.  
<https://doi.org/10.5688/aj720105>
- Wang, S., & Vásquez, C. (2012). Web 2.0 and Second Language Learning: What Does the Research Tell Us? *CALICO Journal; San Marcos*, 29(3), n/a.
- Warschauer, M. (1997). Computer-mediated collaborative learning: Theory and practice. *Modern Language Journal*, 81(4), 470–481.
- Wear, D. (2003). Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Academic Medicine: Journal of the Association of American Medical Colleges*, 78(6), 549–554. <https://doi.org/10.1097/00001888-200306000-00002>
- Wear, D., Kumagai, A. K., Varley, J., & Zarconi, J. (2012). Cultural competency 2.0: exploring the concept of “difference” in engagement with the other. *Academic*

- Medicine: Journal of the Association of American Medical Colleges*, 87(6), 752–758.  
<https://doi.org/10.1097/ACM.0b013e318253cef8>
- Wear, D., Zarconi, J., Garden, R., & Jones, T. (2012). Reflection in/and writing: pedagogy and practice in medical education. *Academic Medicine: Journal of the Association of American Medical Colleges*, 87(5), 603–609.  
<https://doi.org/10.1097/ACM.0b013e31824d22e9>
- Wertsch, J.V. (1991). A sociocultural approach to socially shared cognition. In L.B. Resnick, J.M. Levine, & Teasley, S.D. (Eds.) *Perspectives on socially shared cognition* (85–100). Washington D.C.: American Psychological Association.  
<http://dx.doi.org/10.1037/10096-004>
- Whiteford, G. E. (1998). Intercultural OT: learning, reflection and transformation. *British Journal of Therapy and Rehabilitation*, 5(6), 299–305.
- Wilbur, G. (2016). The staying power of intercultural learning through reflective inquiry. *Reflective Practice*, 17(1), 59–71. <https://doi.org/10.1080/14623943.2015.1123687>
- Wilbur, G. (2017). Who Talks to Whom in Cafes? Adult Student Inquiry for Intercultural Competence. In A. Portera & C. Grant (Eds.), *Intercultural Education and Competences: Challenges and Answers for the Global World* (pp. 145–158). Newcastle upon Tyne: Cambridge Scholars Publishing.
- Williamson, D. (2002). Forward from a Critique of Hofstede’s Model of National Culture. *Human Relations*, 55(11), 1373–1395. <https://doi.org/10.1177/00187267025511006>
- Wink, J., & Putney, L. G. (2002). *A vision of Vygotsky*. Boston: Allyn & Bacon.
- Wong, F. K., Kember, D., Chung, L. Y. F., & Yan, L. Y. (1995). Assessing the level of student reflection from reflective journals. *Journal of Advanced Nursing*, 22(1), 48–57.  
<https://doi.org/10.1046/j.1365-2648.1995.22010048.x>

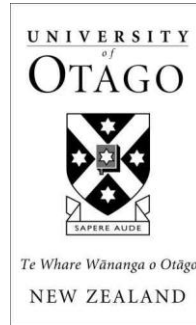
- Yorke, S. (2013). Additional criteria for Assessment of Specialist Medical Education Programs and Professional Development Programs. Medical Council of New Zealand. Retrieved from <http://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Specific-accreditation-assessment-criteria.pdf>
- Zembylas, M. (2008). Engaging with Issues of Cultural Diversity and Discrimination Through Critical Emotional Reflexivity in Online Learning. *Adult Education Quarterly*, 59(1), 61–82. <https://doi.org/10.1177/0741713608325171>
- Ziegahn, L. (2001). ‘Talk’ about culture online: The potential for transformation. *Distance Education*, 22(1), 144–150. <https://doi.org/10.1080/0158791010220109>
- Ziegahn, L. (2005). Critical Reflection on Cultural Difference in the Computer Conference. *Adult Education Quarterly*, 56(1), 39–64. <https://doi.org/10.1177/0741713605280161>

# Appendices

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# Appendix A: Information for Participants



## A Case Study of Medical Students' Reflective Thinking in Online Discussion Forums

### INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

#### **What is the Aim of the Project?**

The purposes of this study are: 1) to determine to what extent computer supported collaborative learning in a blended learning environment (i.e. online discussions and tutorials) is able to foster medical students' reflective thinking related to culture and health, and 2) identify and design pedagogical strategies for promoting reflective practice among culturally diverse medical students using online discussions.

#### **What Type of Participants are being sought?**

Year 2 Medical students enrolled in Healthcare in Community (HIC) and their tutors will be invited to participate in this project at the beginning of Unit 3. Only students in tutorials in which the tutor has also agreed to participate in this research will be sought.

#### **What will Participants be Asked to Do?**

Should you agree to take part in the project, you will be asked to take part in the following:

Tutors:

- Participation in online discussions to fostered reflective thinking and collaborative learning among medical students discussing issues related to culture and health.
- Audio recorded sessions of tutorials (only two or three tutorials from the total of 28 tutorials in year 2 will be sought).

- Complete a questionnaire on the efficacy of online discussions to promote reflective thinking in students.
- Tutors may be asked to participate in a discussion with other tutors or semi-structured interviews where they will be asked open ended questions. The general line of questioning includes reflective thinking in medical education. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the unlikely event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

Medical students:

- Complete a brief questionnaire that includes demographic information (see details in next section)
- Make available their online discussions in Unit 3: Culture and Health, so that they can be analysed for levels of reflection.
- Complete a brief questionnaire at the end of Unit 3 on their experience of online discussion forums.
- Members of two or three tutorial groups may be asked to consent to digitally record sessions of tutorials (separate consent will be sought)

### **What Data or Information will be Collected and What Use will be Made of it?**

The online discussions will be anonymised by removing the student's name and assigning identifier names to the transcripts. Some tutorials (2-3) will be audio recorded and then transcribed and anonymised using identifier names. The transcripts of online discussions and audio recorded tutorials will be retained and analysed for frequency and levels of reflective thinking of medical students about issues related to culture and health. Participants of audio recorded sessions will be asked to provide their student ID number so that their reflection in classroom discussions can be compared with their reflection in online discussions.

Because we are investigating reflection about issues related to culture and health, we would like some information about participants. Personal demographic information such as: Date of birth, age, gender, country of birth, length of time lived in country of birth, countries in which you have lived up to now (eg: Australia 10 years then New Zealand 13 years), length of time lived in New Zealand, mother's country of birth, father's country of birth, mother's current country of residence, father's current country of residence; languages spoken will be requested. This data will be used to analyse the impact that cultural background and/or overseas living experience have on levels of reflection in medical students about issues related to culture and health.

The data collected from online discussions and audio recorded tutorials will be analysed to inform the design of a curriculum which promotes reflective practice using collaborative online discussion forums in medicine.

The person conducting this research is a post-graduate student in higher education and is external to the division of Health Sciences. They are not involved in any assessment in health science.

Raw data from this research will only be accessed by the following:

The researcher

The researcher's supervisors (2)

University of Otago transcribers



The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

You are most welcome to request a copy of the results of the project should you wish. You may also view the transcribed data from audio recorded sessions of your own group if you wish.

### **Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

### **What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:

Mary Furnari	and/or	Senior Lecturer, Clinton Golding
Higher Education Development Centre		Higher Education Development Centre
University Telephone Number 479 7228		University Telephone Number 470 4682
Email Address: mary.furnari@otago.ac.nz		Email Address
Clinton.golding@otago.ac.nz		

This study has been approved by the Department stated above. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

## Appendix B: Student Participant Consent Form

### A Case Study of Medical Students' Reflective Thinking in Online Discussion Forums

#### CONSENT FORM FOR MEDICAL STUDENT PARTICIPANTS IN ONLINE DISCUSSIONS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information— *transcripts of online discussions and audio recordings*—will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. The results of the project may be published and available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity;
5. This project has been reviewed and approved by the Higher Education Development Centre (HEDC).

I agree to take part in this project.

Print Name: .....

.....  
(Signature of participant)

.....  
(Date)

## Appendix C: Tutor Participant Consent Form

### A Case Study of Medical Students' Reflective Thinking in Online Discussion Forums

#### CONSENT FORM FOR TUTOR PARTICIPANTS IN ONLINE DISCUSSIONS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information— *transcripts of online discussions and audio recordings*—will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. This project has been reviewed and approved by the Higher Education Development Centre (HEDC).
5. Tutors may be asked to participate in a discussion with other tutors or interview where they will be asked open ended questions. The general line of questioning includes reflective thinking in medical education. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the unlikely event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind;
6. The results of the project may be published and available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

Print Name: .....

.....  
(Signature of participant)

.....  
(Date)

## Appendix D: Making Online Discussions Work

### Making Online Discussions Work for You! [Student]

#### What's in it for you?

- The best way to check your own understanding is to explain it to others.
- The online discussions allow you time to rethink and re-examine the issues being discussed in class.
- By pooling everyone's experience, insights, knowledge and sources of information, you end up with a much better understanding of the subject than you possibly could alone
- By articulating your ideas, challenging other people's views and being challenged ourselves, we modify and refine our views.

#### What makes an effective discussion?

- **Construct your messages well**—if you write clearly and make it clear how they fit into the discussion, it's more likely people will read and consider your messages.
- **Use "threading" properly.** If someone replies to a message, then someone replies to a reply and so on, then the whole 'chain' of messages is called a thread, and the conferencing software will make it easy to follow a thread. If you are introducing a new topic, don't reply to an existing message, start a new thread with a new and relevant subject line.
- **Give reasons for your opinions.** It's hard to discuss something with someone if they just state what they think without justification—*give examples from personal experience or other evidence*
- **Invite responses to your messages.** (e.g. "Do you agree with me here?" or "Have I left anything out?")
- **Draw each other into the discussion** (e.g. "What evidence is there that..." or "Why do you think that..." or "What do you mean by...")
- **Find areas of agreement or disagreement** (e.g. "I agree/disagree about...because..." or "But what if..." or "On the other hand...because...").
- **Don't be defensive about your opinions** if people disagree—the discussion is not a competition to be the most 'right', it is a cooperative effort to improve everyone's understanding. And it's OK to change your mind once you hear other arguments
- **Try to build on what others have said,** look for areas the group has not covered, try to look at issues from multiple angles

As the discussion progresses, especially if it is lively and interesting, there starts to be a need to make sense of it all. Sometimes the tutor will do this, but anyone can start to do it as well.

- **Summarise**—bring all important points from the discussion together, highlighting decisions or areas of agreement, and acknowledge individual contributions (e.g. "Jo said... and Jill made the point that..."), but without becoming an enormous long list.
- **Refocus**—pull the discussion back if gets too far off-topic (e.g. We seem to have strayed from the point here...")

- **Weave**—pull together threads and ideas, looking for patterns, linking discussion in the course materials and beyond. Weaving goes beyond summarising. For example: “We’ve looked at ... but there’s the whole issue of... which fits in...” or “What if we took the idea of.. and applied it to...”

Adapted from (Plumpton, 2005)

## Making Online Discussions Work & Encouraging Reflection [Tutor]

### Key messages to students:

- Keep it brief—keep to 200 words, long posts are difficult to read online
- Post & reply by deadline
- Write clearly and give reasons for your opinions (e.g. give examples from your experience, draw on other evidence, try to apply theory to practice)
- Build upon what others have said
- Week 1 discussion: use “case threads” (i.e. keep all comments related to particular case in Orr et al. article in one thread)
- Week 2 task is very open ended –feel free to raise issues or ideas not discussed in class

### What’s in it for your students?

- The best way to check their own understanding is to explain it to others.
- The online discussions allow them time to rethink and re-examine the issues being discussed in class.
- By pooling everyone’s experience, insights, knowledge and sources of information, they end up with a much better understanding of the subject
- By articulating their ideas, challenging other people’s views and being challenged themselves they modify and refine their views.

### Ways to encourage critical reflection:

- Encourage students to draw parallels to their personal experiences, and the lessons they have learned from them
- Encourage students to reflect on the origin or source of their beliefs—recount thinking or experiential processes that led them to hold a certain belief
- Encourage students to think critically about the information presented and how and when they incorporate new information
- Ask questions that encourage students to examine their own assumptions and beliefs

### Ways to improve online discussions & learning:

- Ask follow up questions
- **Summarise**—bring important points from the discussion together, highlighting decisions or areas of agreement, and acknowledge individual contributions (e.g. “Jo said... and Jill made the point that...), but without becoming an enormous long list.
- **Refocus**—pull the discussion back if gets too far off-topic (e.g. We seem to have strayed from the point here...”)
- **Weave**—pull together threads and ideas, looking for patterns, linking discussion in the course materials and beyond. Weaving goes beyond summarising. For example: “We’ve looked at ... but there’s the whole issue of... which fits in...” or “What if we took the idea of.. and applied it to...”
- **Affirming feedback**—provide feedback when important contributions are made

Adapted from Plumpton, 2005; Curtis, 2006

# Appendix E: Participant Demographic Questionnaire

## A Case Study of Medical Students' Reflective Thinking in Online Discussions

### Participant Demographic Questionnaire

Because we are investigating reflection about issues related to culture and health, we would like some personal demographic information about participants. This information will be anonymised and every effort will be made to ensure confidentiality. The information gathered below will be used to analyse the online discussion data and audio taped sessions where applicable. Thank you for agreeing to participate in this research and providing this information.

---

Name (please print) \_\_\_\_\_

Date of birth: \_\_\_\_\_ (day/mo/year)      Age: \_\_\_\_\_      Gender: M/F (circle one)

Country of birth: \_\_\_\_\_

Length of time lived in country of birth: \_\_\_\_\_

Countries in which you have lived up to now (eg: Australia 10 years then New Zealand 13 years):

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Mother's country of birth: \_\_\_\_\_ Father's country of birth: \_\_\_\_\_

Mother's current country of residence: \_\_\_\_\_

Father's current country of residence: \_\_\_\_\_

Languages spoken: \_\_\_\_\_

International Student on student visa: Y/N (circle one)

## Appendix F: Participant Feedback Questionnaires

# A Case Study of Medical Students' Reflective Thinking in Online Discussion Forums

## Student Feedback Questionnaire

1. How did the online discussion forums influence your learning about culture and health in Unit 3?
2. How did the online discussion forums influence your reflective practice?
3. How do online discussion forums compare to worksheets or the reflective template to assist you in your learning and reflective practice?
4. What are you taking away from the Culture & Health unit as a future doctor?



**A Case Study of Medical Students' Reflective Thinking in Online  
Discussion Forums  
Tutor Feedback Questionnaire**

1. To what extent did you participate in your tutorial online discussion forums?  
(circle one)
  - a. 3-10 hours per stream
  - b. 2-3 hours per stream
  - c. .5 – 1 hour per stream
  - d. None
  
2. If you did participate, what value did the online discussion forums have for student learning and reflective practice in this unit?
  
  
  
  
  
  
  
  
  
  
3. What were the disadvantages or drawbacks of online discussion forums?
  
  
  
  
  
  
  
  
  
  
4. Please share any ideas or suggestions you have for improving this unit.

## Appendix G: Reflective Framework

### Framework to assess online reflection

Definition of level of reflection	Descriptions (Kember et al., 2008) <i>Italic text from other sources</i>	Exemplars (Adapted from Harland & Wondra, 2011)
<b>Understanding</b>  <i>Intercultural clinical case is described in light of course content or theory, but without relating it to personal experience or future practice</i>	<ul style="list-style-type: none"> <li>• Evidence of understanding of concept or topic — searches for underlying meaning (evidence of deep approach to learning)</li> <li>• Post confined to application of theory</li> <li>• Reliance on what was in the textbook or lecture notes</li> <li>• Concepts are understood as theory without being related to personal experiences or practice applications</li> <li>• Theory is not related to a practical situation</li> <li>• No consideration of how a concept relates to personal experience (concepts have no personal meaning)</li> </ul>	<ul style="list-style-type: none"> <li>• Doctor (and/or patient, family) roles analysed, giving possible reasons for actions taken, but with limited justification</li> <li>• connects intercultural effectiveness of medical providers in cross-cultural clinical cases with theory or course content</li> <li>• post shows no analysis of how this understanding would translate into student's future practice</li> </ul>
<b>Practical reflection</b>  <i>Course content/theory is applied to intercultural clinical case and /or helps shape a personal philosophy and/or new knowledge is related to personal experience or future practice</i>	<ul style="list-style-type: none"> <li>• Theory or concepts are applied to practical /clinical situations or related to personal experience</li> <li>• Concepts are interpreted in relation to personal experience</li> <li>• There are personal insights which go beyond book theory</li> </ul>	<ul style="list-style-type: none"> <li>• Doctor and/or patient, family behaviours analysed, exploring possible reasons and explanations for actions in depth, making connections to theory</li> <li>• Personal experiences are used to evaluate course content or intercultural clinical case, in attempt to apply concepts to future practice</li> <li>• Reflection is personalized, addressing effect on clinical practice or specific future clinical practices</li> </ul>

		<ul style="list-style-type: none"> <li>Strong connections made between intercultural effectiveness and good clinical practice</li> </ul>
<b>Critical reflection</b> <ul style="list-style-type: none"> <li>Critically reviews assumptions, shows evidence of a change in perspective and/or a new conceptual framework is formed</li> <li>Critical reflection is unlikely to occur frequently</li> </ul>	<ul style="list-style-type: none"> <li><i>Questions the validity of a belief, assumption, attitude (Kember et al., 1999), or</i></li> <li><i>Explores and critiques assumptions, values and beliefs and/or biases and considers consequences of actions (Wald et al.2012), or</i></li> <li><i>Consequences are considered so that they can be included in a deeper understanding or reinterpretation of the problem (Wallman et al., 2008), or</i></li> <li><i>Gives reasons for decision(s) or events which take into account the broader historical, social, and/or political contexts (Hatton &amp; Smith, 1995), or</i></li> <li><i>Demonstrates awareness that actions and events are located in and explained by references to multiple perspectives (Hatton &amp; Smith, 1995)</i></li> </ul>	<ul style="list-style-type: none"> <li>Doctor (and/or patient, family) roles/actions critically analysed, taking in broader historical, social and/or political context or critiquing assumptions, values, beliefs or biases</li> <li>Analysis of intercultural clinical case provides an example for a fundamental shift in thinking over a fundamental belief</li> <li>Reflection is internalized, showing evidence of a change in perspective over a fundamental belief</li> <li>Connects intercultural effectiveness to future clinical practice, may include dissatisfaction with existing frameworks, but must also explain new framework</li> </ul>